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ABSTRACT

Constituting an overview of a 10-volume report on the historical development and contemporary activities (1966-1973) of each of the 8 administrative Area Offices of the Indian Health Service (IHS) Mental Health Programs, this volume includes: the methods used for data collection (personal interviews with both past and present IHS key officials, area site visits, and examination of area reports); the report's limitations; the historical context for viewing the introduction of Mental Health Programs into IHS; the Headquarters for Mental Health Programs located in Albuquerque, New Mexico; the major accomplishments of IHS Mental Health Programs; selected themes appearing in the Area narratives (often in terms of polarities of opinion and practice); and 76 specific recommendations for identified problem areas. Recommendations re: issues yet to be resolved include: need for epidemiologic data; adaptation and integration of mental health services with indigenous cultures and practices; balance between direct and indirect mental health services; mental health consultation activities with other IHS staff and external agencies; services for special populations; alcoholism and alcohol abuse; drug abuse and inhalents; accidents, violence, and suicide; issues internal to IHS and mental health program administration (evaluation; recruitment, selection and retention of professional and paraprofessional personnel; institutional racism; etc.). (JC)

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Vol. 1, Set 1

ED133105

OVERVIEW AND RECOMMENDATIONS

Service Networks
and
Patterns of Utilization

Mental Health Programs I.H.S.

Partial fulfillment of
Contract No. 110-73-342

U.S. DEPARTMENT OF HEALTH
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OVERVIEW
AND
RECOMMENDATIONS

1975

IHS Contract No. IHS HSM 110-73-342

A documentary narrative in partial fulfillment of contract entitled:

Service Networks and Patterns of Utilization
Mental Health Programs
Indian Health Service

Prepared by

Carolyn L. Attneave, Ph.D. and Morton Beiser, M.D.

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In addition, acknowledgment is due to the cooperation of the Area Chiefs of Mental Health Services, and the Headquarters staff of IHS for their complete cooperation in making available records and documents, arranging access to personnel at all levels, and reviewing of drafts of the manuscript relevant to their activities. It is not easy to expose oneself frankly to persons outside one's own system, but the IHS staff has courageously done so and we have endeavored in return to make the factual narrative one which they would tell had they time free of current demands and on-going duties to do so.

The Department of Behavioral Sciences of the Harvard School of Public Health and the Association on American Indian Affairs have been supportive of staff needs for time and facilities, and have loaned materials from personal libraries relating to the development of IHS and its Mental Health Programs.

In acknowledging our indebtedness we must not give the impression that we wish to delegate responsibility for controversial interpretations, errors of omission and commission or overall organization of the report. These, together with the opinions expressed, are our own.

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I. DESCRIPTION OF REPORT

This is the final chapter of a nine chapter report in partial fulfillment of IHS contract IHS HSM 110-73-342. This commentary "Overview and Recommendation" chapter is the initiation of an evaluation process which could not have been designed and carried out prior to the documentation and narration of the earlier eight chapters which present an historical and descriptive account of each of the eight administrative Areas of IHS Mental Health Programs. It is hoped that the information contained in the nine basic chapters will provide the base line for generating evaluation studies which will relate to the contexts and goals of each of the programs. It was to fill this gap that these histories were prepared, since, as in many developing institutions, staff within each Area and at the Mental Health Program Headquarters level have been too busy delivering services to record and synthesize accounts of their activities.

Another use to which much of this material is already being put, and for which it may prove widely useful, is that of an orientation work for new staff members, interested persons in legislatures, tribal governments, professional schools, and other related agencies.

A. Format

The eight Area chapters contain both historical and contemporary program descriptions as well as general conclusions as to the accomplishments and problems remaining to be solved in the Area discussed. Each is designed as a self-contained narrative which can be read independently of any of the others. The Area reports have not been placed in any sequence. However, if one is interested in reading all of the Area narratives, then it may be of interest to follow an historical sequence: Navajo, Alaska and Aberdeen Areas (Pine Ridge) were started in 1966. The Billings and Portland Areas each followed a pattern of Area interest and collaboration with residency training programs. This collaboration began as early as 1966, in Billings, with placement of Residents on reservations, and from the men with this experience the first staff were selected in 1968. The Albuquerque Area began its program in 1968 when a former IHS General Medical Officer became available at the completion of a residency in psychiatry. Phoenix also began formal Mental Health Program development at about this time, although less historical material was retrievable in this Area than in the others. Tucson Sub-Area, which is under the separate administration of the IHS Office of Research and Development, has a tribally-operated program of psychological services linked both to the Health Programs Systems Information Center and the Papago Health Board. This program is included in the narrative of the Phoenix Area. Oklahoma City Area was the last to have a formal program and staff, not being allocated funds until 1969-70.

These chapters describing the history of the development of Mental Health Programs in each Area of IHS Mental Health, begin with the first date of formal introduction of staff, but also include as much prior history of mental health efforts and groundwork as was made available by the Area Office. Each Area chapter is based not only on the records available in that Area, but on site visits to field programs, and where possible, interviews with key persons no longer in that Area or active in IHS. With the exception of this section, entitled Overview and Recommendation, there is an attempt in so far as possible to allow the staffs to tell their own stories and describe the programs as they have conceptualized them.

This final overview section describes the methods used for collecting data, the limitations and topics omitted, and provides an historical context for viewing the introduction of Mental Health Programs into IHS, as well as a description of the Headquarters for Mental Health Programs located in Albuquerque, New Mexico.

Following this narrative material is a recapitulation of the major accomplishments of the IHS Mental Health Programs from their beginning in Fiscal '66 to Fiscal '74. In addition selected themes that appear in the Area narratives are given a general statement, often in terms of polarities of opinion and practice, and recommendations are made for steps in the resolution of problems which have been observed.* These are included with some humility, and include ways in which the evaluative process thus begun can be continued and made more explicit.

Appendices collect together several documents which relate to the program at a national level:

-A glossary of IHS administrative titles for those unfamiliar with this terminology;

-A proposed career ladder, including job descriptions and training requirements for paraprofessional staff;

-A copy of the current Patient Problem Oriented Record, which is not in use and will make available computerized summaries of patient characteristics and staff activities (subject to analysis in Contract No. 240-75-001);

-A bibliographic listing of papers published in professional journals by IHS Mental Health staff during and/or pertaining to their IHS Mental Health experience;

-An Index to the total report.

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*Recommendations within the text of the overview chapter have been underlined.

It is hoped that this chapter and its index will facilitate comparison between Areas, as well as the location of material relevant to a wide variety of topics.

B. Omissions

There are a number of topics not treated extensively, if at all in this report.

(1) IHS has a relationship to the United Southeastern Tribes which once were subsumed under the Oklahoma City Area Office. Because of the relative newness of this separate identity, and the lack of formal funding and identification of Mental Health Programs until 1974-75, the United Southeastern Tribes have not been included. It is hoped that this omission will be temporary, and that a chapter describing their Mental Health Programs and planning may be prepared in the future, possibly by United Southeastern Tribes themselves.

(2) The original contact with IHS called for a compilation of patient records and an epidemiological analysis. Unfortunately, the records of Mental Health staff activities and patient contacts could not be retrieved from their interdigitation with Ambulatory Care Records and dispersion in IHS hospital files. Prior to 1974 no Area had solved this problem for the entire Area, but where such data was available for selected staff, or for a particular Service Unit, it has been included. The Uniform Computerized Patient Contact Records, introduced in Fiscal 1973 throughout IHS as the Mental Health and Social Services Problem Oriented Record, provides much of this information, but was made available too late for inclusion in this report. It will be the subject of a subsequent report under Contract No. 240-75-001 to be completed in the fall of 1975.. In addition a separate contract to the National Association of Indian Social Workers

(Contract No. HSM 110-73-372) was let parallel to this project to measure consumer needs and degrees of satisifaction with IHS Mental Health Programs.

To some extent, because of these omissions the phrase 'patterns of utilization' in the title of the contract under which this work was done is misleading.

(3) The Mental Health Programs of IHS have been separately budgeted wherever they have been introduced since 1966. In the Area narratives the mental health components of Social Services Branch staff which antedated the specialized staffing and programs of the Mental Health Programs have been presented whenever they could be documented. Subsequent collaborative functions have been carried out in several IHS Areas, and these too are integrated into the report. However, much activity of the Social Services Branch has not been reported here subsequent to 1966. The analysis of patient records cited above will again integrate contemporary Social Services and Mental Health activities, but the gap in recording Social Services Branch activities should be filled.

(4) An analysis of the IHS Mental Health budgets, both nationally and for each Area, is not made in this report. Such evaluations of cost effectiveness are futile exercises until the goals of the programs, the needs of the populations served, and the settings in which tasks are performed can be specified. Formal budget information is a matter of public record since the Mental Health Programs are funded through separate appropriations as line items, and not confounded with the overall IHS budget.

In addition, each Area Chief used ingenuity to multiply resources through cooperative agreements with state and other agencies, the development of volunteer and informal resources, exchanges with other Branches of IHS (often brought about as a result of in-service training as well as through collaborative planning), and by other means. A few fees and local grants for special projects are also incorporated into Mental Health Program development and expansion.

Moreover, each year ends with additional funding erratically made available due to unanticipated surplusses or releases of funds at the federal level. The ability to have readily implemented contigency plans to make use of the funds, and the emergencies which arise from the lack of certainty of adequate funding are all problems which require specialized analysis beyond the scope of this report.

Such studies are needed to complete the evaluation of IHS itself and its Mental Health Programs in particular. However, it was felt that it would be premature to do so at this time, until more adequate understanding was obtained of the dimensions of the program, its goals and its needs. When this phase of evaluation is undertaken it should be in close collaboration with IHS staff, and in terms of the goals set for themselves by that staff, as well as in terms of external criteria of program effectiveness and adequacy.

C. Source Material for This Report.

In preparing this overview chapter and throughout the Area narratives, much use is made of internal documents prepared as Service Unit and Area reports. It is well understood that such documents are often prepared with multiple purposes in mind: expressions of opinion, justification for deviations from routines, competitive declarations of need for a share of scarce resources, etc. Nevertheless, these still constitute the best evidence of the priorities, program details, and flavor of the actual programs at the point in time they were written up. Such materials, as well as the relevant quotations from published articles by IHS Mental Health staff members, are set in single space so as to distinguish them from narrative and interpretive sections prepared by the research staff. The project staff appreciate the freedom of access to these documents. and the cooperation of Area Chiefs. The responsibility for the selection of these illustrative materials rests with the authors of this report. Although differences of opinion expressed by Area Chiefs have been considered, the contractors have reserved the right of final decision as to inclusion or exclusion of any particular document.

An additional source of documentary data was the reporting of staff activities during 1973 collected during visits to each Area, and by mail. This has proved most useful in documenting consultation activities of staff and providing a cross-cultural overview that enabled the contractors to focus their attention on topics relevant to IHS instead of using a priori criteria of Mental Health Program and staff activities. In each Area chapter there is a compilation of consultation activities based on this 1973 data.

In addition, the contractors visited all eight Areas, and a total of 50 Service Units during the data collection phase of this contract. Interviews were arranged with key personnel who were no longer staff of or employed by IHS, and with Area Directors and other Branch Chiefs, Service Unit Directors, and others cognizant of both the historical and contemporary aspects of IHS Mental Health Program development. The sampling desired was discussed with each Area Chief, who then arranged the final selection of Service Units to be visited within the constraints of travel limitations and availability of personnel at the time of the site visits. In the Billings and Navajo Areas, Area-wide staff meetings enabled one of the contractors to meet all IHS Mental Health staff. At the National Training Conference in Albuquerque (May 1974) and the

American Orthopsychiatric Association meetings in San Francisco (May 1973) staffs not visited were available for discussions and interviews by both contractors, in addition to follow up conferences with many of those who had been visited.

Coordination of activities through Headquarters IHS staff both in Albuquerque and Washington, D.C. has been supportive and facilitative. It is regretted that Mabel Ross, M.D., former consultant to USPHS, and Marion Andrews, retired Chief of Social Service, were not available for interviews since their role in developing Mental Health Programs antedates 1966, and it is known that they were instrumental in developing the foundations for the initial budget appropriations and program plans. It is also apparent that their continued support of a "Branch" parallel to Social Service laid a foundation for the complementary and supplementary roles of both staffs.

II. THE CONTEXT

A. History of IHS Mental Health Programs

1. Myths About Origins of IHS Mental Health Programs

In tracing the history of the development of the Mental Health Programs of the Indian Health Service, two persistent and opposing myths recur. Like the children's candy called 'jawbreakers' each myth is an acretion of layers around a kernel of truth. One myth suggests that Mental Health Programs came into being because in 1966 there were available three psychiatrists who, in selecting IHS as the branch of the services for their draft obligation,made unexpectedly available a source of manpower and ideas. This has a kernel of truth, since it was at this time that psychiatrists first became available to IHS via the draft, and this source of psychiatrists was utilized until the end of Selective Service conscription in 1972. It is also true that the three men, Robert Bergman, M.D., Joseph Bloom, M.D., and Carl Mindell, M.D., were extraordinarly capable and well prepared for their roles. Their ideas have had a far reaching impact on the shape of IHS Mental Health Programs. However, the idea of mental health services and the planning for it began long before 1965. Indeed, Dr. Bergman and possibly the other two were involved in preliminary preparation for their roles before completing their residencies, under the guidance of a number of IHS staff including Mabel Ross, M.D. and consultants such as George Meyer, M.D. then of the University of Chicago faculty.

This myth then, runs directly counter to the other major myth, namely that IHS has always been interested in the emotional problems and mental illnesses of its Indian clientele, and that the formal Mental Health Programs were simply a mechanism for expressing this interest more concretely and formally than in the past. This second myth certainly has its kernel of truth. Dorothy Lawson, retired Chief of IHS Social Service has shared much information about the early days of IHS when this Branch was particularly concerned with the humanistic elements of delivering health care to the Indian population.

The sometimes almost heroic efforts of the Social Work staff in securing the services of medicine men, particularly among the Navajo and Apache make good anecdotal material and much of it is included in each Area report in the story of the development of Mental Health Services in each locality. In Aberdeen the use of contract funds, administered through the Social Services Branch, provided mental hospital care for Indians from the time of abolishment of the practice of sending disturbed and apparently psychotic Indian patients to St. Elizabeth's Hospital in Washington, D.C.. In the Billings Area the Social Services Branch under Frances Dixon, long before the finalizing of funds for a formal mental health program, developed cooperative arrangements with the Sheridan VA Hospital, and with the Residency training program of the University of Colorado in Denver under James Barter, M.D. Both Public Health Nurses and Social Workers in the Oklahoma Area provided active liaison with local mental health facilities in Oklahoma antedating that Area's formal Mental Health Program. It is probable that in Portland, Alaska, Albuquerque and Phoenix such anecdotal material has been lost in the turnover of personnel — a factor which contributes repeatedly to the loss of continuity in recording historical material. Indeed, the lack of channels within IHS for the transmission of history creates a cyclical phenomenon that makes it appear in some Areas as though new staff were engaged in re-inventing mental health programs — "discovering the wheel" over and over again.

Certainly this kind of interest in Indian patients and mental health was endemic in IHS, although the grim realities of urgent physical needs for treating accident victims, ending the Tuberculosis epidemic, or reducing infant mortality often created a crisis atmosphere that sapped staff energies and diverted attention from human relationships and emotional stress in order to save life itself. To some extent many units of IHS operate still in this fashion. It is a fairly commonplace event to be told that the staff is too busy "mopping the blood off the floor" to be able to give attention to mental health —as if the feelings of patients, the time puzzling out for cross-cultural interactions, and the goal of raising the level of functioning of Indian and Native peoples who survived infection or trauma were all luxuries for which IHS had not time.

Since such an attitude exists along side the active Mental Health Programs of today, it is not unlikely that it has been historically present as the IHS developed, and this renders the myth of always having Mental Health resources and concepts operative only partially true.

2. Initial Status of Mental Health in IHS

Actually, when IHS was formed as a Division of USPHS in 1955, its chief mission was general medical and surgical care. It had been determined after long study that the use of USPHS and military medical and surgical specialists was not adequate. It had also been determined that detaching those personnel from their other federal services and placing them under the administration of the Bureau of Indian Affairs was also impractical, since the BIA with its many non-medical problems often seemed unable or unwilling to provide from its own meager resources the logistic support and administrative sanctions that enabled physicians, nurses, dentists and sanitarians to provide adequate medical care. Many congressional hearings were held, as well as a conference called by the Association on American Indian Affairs, a non-governmental association instituted for the gathering of information and coordination of interests from many sources in the problems of American Indians and their solutions.

In 1955 the Congress established within USPHS a special Division, charged with providing health care to American Indians, and appropriations based on the reservation populations began to be utilized to develop facilities and personnel specialized in this field. A special report based on the findings of a review of the needs/problems of the Indian populations and the projected health care needs to solve them was published in 1957:

This report, Health Services for American Indians, PHS Publication No. 531, is a comprehensive report on health services being delivered and needed by the American Indian population according to Bureau of Indian Affairs definitions. It was prepared to guide the Surgeon General and the US Congress in the development of the appropriate plans and budgets for the newly-created Division of Indian Health as it took over the responsibility for health care of Indian peoples from the Bureau of Indian Affairs. As such it conducted field surveys which included clinical examinations, interviews regarding health of family members and their use of medical facilities, economic and educational factors, and historical ethnographic and demographic data. The appendices also contain documents from earlier reports such as the Merriam Report in 1928, and other basic reference material.

In general this is a valuable document, and its chief limitation is that it has not been replicated since the work was done 20 years ago in 1956. Most of the basic recommendations still form the patterns for developing delivery of health care by IHS, and a replication would enable some real judgment of progress made and goals still to be achieved in the overall fields of general medical care and preventive and public health services.

The chief emphasis of the 1957 report was on general medical care, especially contagious and infectious diseases, and on the preventive aspects included in public health, such as sanitation, water supply, housing, etc. There is some note taken of the need for coordination with state and county agencies, a topic generally assumed to be the task of the medical social worker when related to patient care. There were 8 social workers of this type employed by BIA who transferred or were replaced by the new USPHS program in Indian Health. This was almost immediately increased to a total of 14. "3 at Area offices, 8 at Indian Hospitals, and 2 at Indian Health Centers, besides the Director. This total still falls short of meeting minimum requirements." (op. cit. p. 114)

The tasks of these social workers were primarily focused on the needs of tuberculosis patients and to some extent the families of such patients. A second priority was given to the social aspects of maternal and child health problems, and a third to aged, handicapped or abandoned medical care recipients. Roles were divided between cooperation with physicians, nurses or other medical personnel and exploring the availability of other health and welfare services that might be made available, such as prosthetic devices, nursing home care, welfare assistance, etc.

Beyond these staff, there were no others at that time directly responsible for the mental health needs, however broadly defined, of the Indian population. In fact, such a topic was not planned in the survey with the same care and attention to detail as were other health topics. Although the record of the procedures includes the International Statistical Classification Codes for psychoses, psychoneurosis and personality disorders, including 'nervousness' no report of findings under these headings is given and apparently no psychiatrists were included in the clinical teams examining sample reservation populations. (op. cit. p. 292) In general the report is limited to the observations and results of inquiries made by NIMH and Regional HEW staff (op. cit. pp. 151-153)

Statistics are given for the number of Indians in 7 state hosptials for the mentally ill and St. Elizabeth's Hospital in Washington, D.C., with observations that it had been BIA policy since the closing of the Canton Indian Asylum in South Dakota to use local state facilities for this infrequent need. The statements about this aspect of care are sufficiently succinct and cogent that they are quoted here in full:

> . . . In 1956, the average daily census for mental hospitals reporting Indian patients, and for whom the Public Health Service made reimbursement through contractual arrangements was:

Hospital	Average daily census
TOTAL.	204
North Dakota (Jamestown)	10
South Dakota (Yankton)	15
Montana State	14
New Mexico State	12
Arizona State	72
Nevada State	9
St. Elizabeths, Washington, D.C.	72

> The Public Health Service, in many States, pays the State for the cost of hospitalization of these Indians. If there is sufficient wealth, the tribal council may arrange for private hospitalization of ill persons. Frequently the patient is taken to the place of commitment or to the hospital by tribal police. There is usually no stigma attached to hospitalization and the patient is accepted on return home. However, there is objection to the police role in the commitment. Instances were noted where mentally ill persons who could profit from hospital treatment were hidden by their families so that they might be "protected from the police."
>
> The very few public mental health clinics available in areas where Indians reside may offer treatment to Indians. However, professional personnel usually do not have the background required to understand and help the Indian adult or child. In some States mental health consultation is occasionally available to teachers employed in schools where there are Indian pupils. (loc. cit.)

Taken with present knowledge of the problems arising from the use of state and local facilities, and of the utilization of appropriate care once it becomes available, these figures are undoubtedly underestimates of the need for psychiatric services.

However, the staff of the project seemed aware of this, and also of the fact that there were many non-hospitalized persons in need of mental health care among the Indian populations. Some of the stress leading to emotional mental breakdowns is identified. They also describe some of the difficulties in planning.delivery of mental health services to the Indian population.

Mental Health of Indians [p. 151]

> It has been pointed out in earlier chapters of this report that customs and cultural values vary from group to group according to tribal affiliations and to the degree in which particular groups have accepted the customs and values of non-Indian groups with which they are associated. Correspondingly, Indian concepts of what constitutes mental illness or health also vary from tribe to tribe.
>
> Behavior deviations which non-Indians consider to be signs of mental illness are seen in Indians but, as a rule, Indians are more tolerant of mentally ill and mentally retarded persons than are non-Indians. As a result of this, these people often are cared for within the family and community instead of being placed in institutions. This tolerance is seen ordinarily in an inverse ratio to the degree in which the Indian group has assimilated the non-Indian culture and given up Indian customs and values.
>
> Mental illness, irrespective of cultural patterns and conflicts, occurs in Indians as it does in other people. However, much of the aberrant behavior seen is evidence of tensions arising from contact with the non-Indian cultures. These tensions may arise as a result of failure of efforts to live and work with non-Indians. The Indian, reared in his own culture on the reservation, is poorly equipped to compete and is also frequently rebuffed in his efforts to join the non-Indian group. Often he has partially abandoned his Indian ways and is no longer able to accept the life on the reservation. A conflict between cultures then goes on inside him, resulting in signs of maladjustment. Breakdown in communication because of differences in language and conceptualization complicate the problem still further.
>
> Financial support given in ways which foster dependence, coupled with the difficulties of making a move into a non-Indian world, frequently results in passive acceptance and dulling of initiative which is interpreted as "laziness."

Special Mental Health Problems [p. 152]

ALCOHOL. — The amount of alcohol consumed varies greatly among tribes and among individuals within the tribes. The extent of this alcohol consumption is a matter of great concern to both Indian and non-Indian populations. Alcohol offers an escape from frustration and tension and frequently more desirable recreational outlets are not available. This situation is not too different from that which is found in non-Indian populations in similar circumstances. Social problems, already troublesome, are made worse and acute crises are precipitated by the excessive use of alcohol. The concomitant problems -- dissolution of families, desertion of children, unemployment, and accidents — are the same in all cultural groups. On one reservation, the older children in some families were so disturbed by the extreme squalor at home, which resulted from alcoholic debauches and neglect, that they deliberately committed delinquent acts in order to be apprehended and removed from the situation.

ACCIDENTS AND VIOLENCE. -- It is unwise to generalize with regard to psychological motivations without more information based upon study of a large number of individual situations. However, it is well recognized that psychological factors play a part in accident causation, and accident rates are high among Indian population groups. Alcohol is also an important factor here.

It is difficult to understand self-mutilating behavior of Indians, such as voluntary dismemberment by lying in front of trains or setting oneself on fire. There are comparable modes of reacting to unbearable situations in other cultures, although they may appear to be less dramatic. Behind this dramatic behavior of Indians, there appears to be especially intense frustration.

CHILD ABANDONMENT. -- These special problems, and others such as desertion, are related to the total life situation of the Indian and to his efforts to find a solution through psychological means by trying to escape from problems which he cannot solve. As stated before in this report, the reaction of the Indian depends upon the degree to which he has discarded his old customs and values and to which he has adopted non-Indian values and customs. In some situations he has abandoned most of his own and taken on few of the non-Indian ways. Where this has involved an entire tribe, the results may be observed in complete stultification of both individual and group effort in any direction and in a complete disorganization of family and community structure.

Conclusions [pp. 152-153]

1. An epidemiological study is necessary in order to determine the mental health problems of Indians and the effectiveness of available programs. The study should indicate the scope and nature of the problems in general and point up the special factors, such as concepts regarding mental illness and the mentally ill, operative in the individual tribes and situations.

From a review of recent studies made by social scientists and psychiatrists and from the study of specific incidents, it should be possible to determine the elements in Indian cultures, non-Indian culture, and local circumstances which combine to create tension, conflict, and frustration. In this manner sources of particular conflict can be studied and sound basic plans made with tribal leaders in each group to include preventive and therapeutic mental health elements in the total health program for the Indians.

2. There should be well-planned orientation and inservice programs for all people working with Indians. It is desirable also for all Indian health workers to have a basic understanding of the mental health concepts and principles which apply to all human relationships. Orientation programs should help develop understanding of the cultural values and standards of the non-Indian workers and how these differ from other cultural groups, plus an appreciation of what may be the result of conflicts between differing cultural groups. Inservice programs should help the personnel to make applications to specific groups and individuals with whom they are working in order to help minimize the devastating consequences which arise when one group or person attempts to impose standards on another.

3. Mental health consultation should be available to health, education, and welfare personnel who have intimate working relationships with Indians, especially children. Consultation should be directed toward promotion of more effective functioning by improving understandings and appreciations of how individuals and groups behave under stress of various kinds in day-to-day activities. Health workers should be helped to recognize and use significant tribal and family relationships in establishing and promoting preventive and curative programs in both mental and physical health. In order to minimize problems of adjustment in bilingual groups, nursery schools could be established on the reservation to prepare the children for school, and adult education classes could be used to strengthen English comprehension and use.

4. Adequate programs should be provided for the care and treatment of the mentally ill and retarded. The positive factors of family and group acceptance of the deviant person should be utilized in program planning. Where the deviant behavior of the aged, the retarded, and the chronically mentally ill is accepted by the group, assistance should be directed toward helping support the individual in the family or community. Safeguards should be taken to avoid creating the same feelings of shame and stigma as seen in non-Indian groups by utilizing the positive factors of acceptance of the mentally ill person. The continued development of strong integrated treatment and preventive programs should be encouraged. The provision of better inpatient and outpatient facilities for all groups resident in the State or region is one of the most effective steps in guaranteeing improved care for Indians. To make commitment a medical procedure and to eliminate police intervention wherever possible, commitment procedures should be reviewed from the legal and humanitarian points of view.

5. From the mental health point of view, there is no simple answer to problems such as excessive use of alcohol, high accident rates, child abandonment, and poor social and school adjustments. However, these problems might be approached more profitably from the point of view of symptoms which are the result of tension, unrest, frustration, and changing values, rather than as disease entities or single problems. To be effective, any mental health program must be an integral part of a total program meeting approval of tribal leaders. The dilemma is whether to try to strengthen old values and customs and so preserve the Indian as a separate cultural entity, or to try to accelerate the process of completely acculturating the Indian group under consideration. If the latter course is accepted, the planners must be sure that the Indian will be welcomed into the new culture and will not find himself lost between the old and the new.

3. AAIA National Conference: 1964

By 1964, as the tenth anniversary of the creation of IHS approached, the Association on American Indian Affairs called a conference of IHS staff and outside consultants to discuss the two topics considered then the leading health problems of American Indians: Mental Health and Otitis Media. The portion of the conference devoted to Mental Health, chaired by Alexander Leighton, MD, permitted an exchange of ideas and views from federal officials, Indian community leaders and Mental Health professionals. Particularly noted are the contributions of Mrs. Eunice Larrabee from the Lakota TB & Health Association, Annie Waneeka, Navaj[illegible]ribal Council member, and Sam DeLoria, a Sioux attorney -- all of whom represented the Indian point of view both as individuals and representatives of organized bodies within their local tribal structure.

Throughout the discussion there seemed to be general agreement that in some way IHS should begin to plan for entry into the field of mental health services. However, there were polarities expressed which are still unresolved in 1974, after 8 years of experience with mental health program development. Three such issues are especially noteworthy for their continued lack of resolution.

a. Polarities Around Epidemiologic Needs

The first of these was the problem of whether adequate programs could be planned without basic epidemiologic information. It was the response of Dr. Carruth Wagner, then head of IHS as assistant Surgeon General of USPHS, that t need was so great, and the first priorities so obvious that program development need not wait upon data collection. Others felt that definition of the scope of the problem and the particular needs of Indian peoples would enable adequate and efficient development of mental health programs in an innovative model.*

b. Polarities Around Definition of Mental Health

A second polarization developed around the issue of whether by "mental health programs" was meant a psychiatric service for the acute and chronically ill, to function as other specialty medical programs, and to employ mainly psychiatrists -- or did Mental Health Programs imply the broadly conceived Community Mental Health format, with consultation, education, short term treatment, and innovative community based approaches? Both points of view have been expressed at one time or another in all Areas, and in general the stable and productive programs have achieved a balance betwen traditional and innovative community-oriented activities.

Related to this problem of the definition of the role and function of mental health programs is the relationship of such programs to problems of alcoholism among American Indians. So far as the Indian leadership is concerned a distinction between mental health and alcoholism treatment programs was seen as rather artificial. However, federal funding has been a patchwork of sorts, with funding for alcoholism treatment programs coming from many sources. The Offices of Economic Opportunity and the later formed National Institute for Alcohol Abuse and Alcoholism have until very recently provided the bulk of the funds for personnel, training and staffing of alcoholism treatment programs, with IHS serving as medical and psychiatric consultants, sometimes providing detoxification services involuntarily, and sometimes with planned facilities and programs, and on occasion providing training for alcoholism counselors. The details of such programs can be found in the various Area reports. This issue of who should provide alcoholism treatment, and whether or not it is a component of mental health program development will be discussed at the contemporary level in a later section of this report.

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* Mabel Ross, M.D., Consultant to IHS, took the initiative with the Lakota representatives to plan one of the first programs representing these opposing points of view: Pine Ridge Reservation was selected for careful study and the development of what was hoped would be a model program based upon identified needs. Alaska, then was funded with a traditional orthopsychiatric team to go and find out what the needs were and begin meeting them. In essence this was also true of the Navajo program which began at the same time but without a special appropriation until the following year.

c. Polarities Around Involvement of Indian Peoples

The third persistent issue was the division of opinion as to the degree of involvement of the Indian communities and leadership in the planning and implementation of mental health programs. The mechanisms of advisory boards, of the employment of Indian staff, and the possibilities of danger in the development of community involvement when basic issues of economic and social problems seemed preeminent were all discussed.

The issue of whether or not Indian peoples should be involved is not in question at this time at the national level. Close liaison with Indian advisory boards at the Service Unit, Area and National levels is quite apparent. The alert recruitment of Indian professionals, as well as the development of a cadre of Indian paraprofessionals marks the mental health program distinctively. Sensitivity to cross-cultural issues is a general hallmark of most Area Mental Health Programs.

However, implicit paternalism and distrust of self-determination still occurs at local levels, and sometimes at the Area levels. It is discussed in its current form under the issue of racism within IHS in a later section of this report.

The issues of the need for epidemiological data and for definition of the role and function of Mental Health Programs are also discussed in the Issues and Recommendations section, together with additional polarizing issues noted by the investigators in the course of preparing this report. These three issues, however, have a certain historical importance, along with problems of services to BIA Boarding Schools, problems of budget and other themes that were first stated publicly in this AAIA conference, and have shown themselves to be continued elements in the development of IHS Mental Health Programs to 1974.

4. First Programs Funded: Pine Ridge 1965

As a culmination of planning begun before and out of the support gained during the AAIA conference of 1964, an appropriation was requested for initiating a Mental Health Program as a pilot demonstration on the Pine Ridge Reservation in South Dakota. Congressman Ben Rifel, himself an Oglala Sioux, joined by the strong support of Mrs. Larrabee and others, secured $100,000 for this as a first step, beginning in 1965.

IHS used the services of its psychiatric consultant, Dr. Mabel Ross, who had been part of the AAIA conference to help establish this first mental health program. Dr. Ross was aligned on the side of those who felt that a successful program should be erected on a base of solid data regarding the needs, characteristics and culture of the people to be served. Therefore, in its first year the program began as a research program, rather than as a primarily service oriented program. The first psychiatrist assigned, Dr. Carl Mindell was not available until a year after the initiation of program planning and data gathering.

B. Phasing in of Other Programs

By December of 1965, the Surgeon General's Advisory Committee on Indian Health was sufficiently impressed with the beginnings of the Pine Ridge program to include mention of it in their report as follows:

> The Division's pilot mental health program at Pine Ridge, South Dakota has been activated as a result of favorable congressional action on this fiscal year's budget request. The Division is hopeful that a similar program tailored to the needs of the Alaska Native can be initiated in fiscal year 1967 as the next step in expansion of this vital activity.
>
> The primary thrust of these programs will continue to be preventive in nature with program operations being conducted by the total field staff rather than by a special mental health programs group.
>
> This type of program has been endorsed by the Indian Health committees of the American Academy of Pediatrics, American Academy of General Practice, American Public Health Association, and Association of State and Territorial Health Officers.
>
> Recommendation No. 5
>
> Mental Health
>
> The significant impact of problems of poor mental health upon the total health status of the Indian and Alaska Native dictates the development by the Division of Indian Health of an aggressive mental health program. The major orientation of this program should be toward recognition by all staff of the relation between the cultural and environmental stresses affecting the natives and their mental health disorders. Development of ongoing staff to acquire special competencies is also needed. The pilot project now being conducted on the Pine Ridge, South Dakota Reservation should be extended as rapidly as possible to other Areas within the Division beginning with Alaska.
>
> It is recommended that the Division include mental health as one of its primary objectives in the coming fiscal years and seek an appropriation for this most important activity. (Report of the Surgeon General's Advisory Committee on Indian Health, Dec. 5-8, 1965, Phoenix, AZ, U.S. Department of Health, Education and Welfare.)

With these strong supports, Eugene Rabeau, M.D., who had become Director of the Division of Indian Health, was able to muster the support for an additional appropriation for Alaska, and to arrange for other funds available in the Navajo Area to be put to use to secure the services of Robert Bergman, M.D., for that Area.*

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* In his first year Dr. Bergman's program was supported by monies diverted from funds for solid waste disposal.

1. First Five Years — A Phasing in of Area Programs

The table that follows shows the sequence of appropriations over the five year period during which Mental Health Programs were introduced. Each dollar entry in the body of the table indicates a new additional amount, while the total for each year, based on the continuing of previous appropriation amounts is shown in the last or bottom line of the table for each year.

2. Financing Mental Health Programs

a. Separate Budget Appropriations

By securing separate budget appropriations for Mental Health Programs, in addition to the general budget for IHS, the integrity of the programs was assured in the face of competing needs and variations in interest and priorities at the Area and local level. This continues to be the practice in financing Mental Health Programs in IHS, and as can well be imagined, the method is a mixed blessing. While guaranteeing a fair amount of local autonomy, there are often ambiguous situations in which Mental Health staff are responsible to Service Unit Directors, while also being held responsible for activities, work schedules, and travel which is not under local control but administered from the Area or National Mental Health staff.

So long as most Areas operated as a centralized flying squad of consultants from a base within the Area office, this type of dual administrative line seldom caused problems. However, as decentralization occurs, and particularly with the growth of numbers of Mental Health Workers attashed to Service Units, and as liaison and cooperative arrangements with Social Services and other branches of IHS are developed, the separate budgeting at times causes misunderstandings, tensions, and even crises. The advantages however, are so far seen as out-

Table I: ORIGINAL FUNDS FOR IHS AREA MENTAL HEALTH Teams AND ADDITIONS FOR FIRST FIVE YEARS

	FY 1966			FY 1967			FY 1968			FY 1969			FY 1970		
	POSITIONS		AMOUNT	POSITIONS		AMOUNT*	POSITIONS		AMOUNT	POSITIONS		AMOUNT	POSITIONS		AMOUNT
	New	total	New	New	Total	New	New	Total	New	New	Total	New	New	Total	New
Aberdeen	5	5	$100,00	0	5	-0-	5	10	$50,000	0	10	-0-	0	10	-0-
Albuquerque	-0-	-0-	-0-	-0-	-0-	-0-	2	2	$25,000	2	4	$40,000	3	7	$15,000
Anchorage	-0-	-0-	-0-	5	5	$100,000	-0-	5	-0-	-0-	5	$17,000	3	8	$22,000
Billings	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	1	1	$13,000	-0-	1	-0-
Navajo	-0-	-0-	-0-	1	1	-0-**	3	4	$75,000	3	7	40,000	-0-	7	-0-
Oklahoma	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	7	7	$69,000
Phoenix	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	4	$60,000	-0-	4	-0-
Portland	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	-0-	4	4	$60,000	-0-	4	-0-
Additions for each FY	5		$100,000	5		$100,000	10		$150;000	14		$230,000	18		$156,000
Cumulative totals		5	$100,000	11		200,000		21	$350,000		26	$580,000		48	$736,000

*Once funded postions and amounts were carried from year to year. Only additions are entered here, but cumulative totals for each Fiscal year are entered below.

**The MH position for this year was funded from another source.

One reads the table as follows In the Aberdeen Area 5 positions were funded in FY66 at 100,000, and the same budget and staff continued in FY 67. In FY 68 5 new positions were funded with an additional 50,000,(a total of 10 positions funded at 150,000.) This continued to be the level in Aberdeen through the period recorded.

weighing the disadvantages, and the separate appropriation policy continues.

b. MHCD and Other Hidden Assets

This first table does not actually represent the total amount expended for mental health by IHS, nor indeed all of the personnel available. A number of key persons in each Area over the years have been recipients of Mental Health Career Development Awards, which pays salary and research expenses for a period of five years to young professionals (under the age of 40) who choose a mental health program with which they wish to work in a creative fashion. Several chose IHS and many have at the conclusion of their Award period become regular staff of IHS programs. Others after one or two years have moved to other career lines within the field of mental health broadly defined. Several of these individuals are mentioned in the Area reports as having been in the past, or at present serving IHS in this capacity. Norbert Mintz, Ph.D., Navajo; Barry Mendhlsohn, M.D., Alaska; Billie Von Fumetti, R.N., Portland are examples of MHCD fellows who have made significant contributions to IHS Mental Health Programs. Their salaries, and some of the program expenses are not reflected in the budgeted appropriations during the years that they were recipients of MHCD Awards.

c. Liaison with Tribal and CMHC Programs

Similarly, in several instances tribal contracts, or local Comprehensive Mental Health Centers have provided a vehicle for establishing programs to which IHS contributes a part, but not all of the support and personnel. Outstanding examples of this type of program development are described in connection with Warm Springs in the Portland Area chapter, and also both White River Apache and the Papago Psychological Services in the Phoenix chapter.

Regardless of the staffing pattern held to be ideal, no Area has as yet reached optimum, let alone maximum, staff and facilities for coverage of the population it serves. In some instances effective liaison with local mental health centers and psychiatric resources has increased coverage, as in Phoenix where private psychiatric resources are utilized; in eastern Oregon and northern Arizona, where CMHC's are effective; or in Albuquerque, where contractual arrangements are mutually advantageous both to the Area program and to the Bernallilo CMHC and the Albuquerque Child Guidance Clinic. In other localities, the presence of a local CMHC has not reduced the demands made on IHS because that center was either understaffed, or oriented toward white middle class values and lifestyles, either of which rendered them ineffective to help Indians in distress. Rapid City (Aberdeen Area), with its expanding outreach and community program is a good example of this last type of program which supplements the local CMHC offerings to non-Indians.

d. Alcoholism Programs

Tribal alcoholism programs are also frequently separately funded but dependent upon IHS for consultation, training, medical services, or other portions of their programs. This element of IHS budget planning is becoming increasingly important as the NIAAA grants, which were largely for demonstration purposes, run out, and local tribes look to IHS for continuing support for programs of proven worth. Examples of these programs are described in the Oklahoma Area chapter around the program at Bessie, in the section of the Phoenix chapter describing the Nevada programs operating the Reno Field Station, and in the Portland chapter in connection with the Chemawa Boarding School program on Alcoholism. All Areas participate in this type of relationship, and in the Billings Area it has become a priority project to consolidate and plan for integration with alcoholism programs on every reservation served.

e. Budget for Fiscal Year 1974

These alcoholism program activities are reflected in the budget information conveyed in the table facing page 29. This summarizes the last 1973 and 1974 fiscal years of expenditure of IHS Mental Health Programs, with the funds made available for special alcoholism program use shown in a separate column each year. Looking across both of the tables from FY 1965 to FY 1975 one notes that the increase in numbers of staff budgeted follows a geometric curve.

The number of staff utilized doubles at the end of the first year, then in 2 years, then in 3 years and at the end of 10 years has slightly more than doubled again--4.4 times to be precise. Dollar amounts in the budget follow the same pattern, but at the end of 10 years have 'doubled' only 4.1 times.

It is not possible from this limited information to deduce staff effectiveness, or evaluate actual costs of programs either required or provided. Such studies are needed, and should be developed as evaluation studies progress, as well as being a part of the overall management processes of IHS. However, the purpose of this report is to provide the baseline and context from which such studies may be appropriately designed. This minimal budget information is therefore included, but in no way substitutes for a more detailed analysis -- once some of the issues and polarities are resolved and clear goals are established.

TABLE II: BUDGET: IHS MENTAL HEALTH PROGRAMS, FISCAL YEAR 1974

Area	1973 Positions	Additional Positions	Total 1974	1973 Base	1974 Addition to Base	Special Funds for Alcohol Programs	Total	1973 Funds for Contract Care	1974 Grand Total
Aberdeen	33	3	36	379,000	25,000	0	404,000	29,000	433,000
Bemidji	4	2	6	73,000	10,000	0	83,000	0	83,000
Albuquerque	19	3	22	280,000	20,000	0	30,000	16,000	316,000
Anchorage	20	3	23	325,000	20,000	20,000	365,000	30,000	395,000
Billings	23	2	25	305,000	20,000	0	325,000	14,500	339,500
Navajo	23	2	25	300,500	25,000	30,000	355,500	45,000	400,500
Gallup Inpatient	15	5	20	228,000	30,000	0	258,000	0	258,000
Oklahoma	18	2	20	254,000	25,000	0	279,000	30,000	300,000
USET	—	0	—	32,000	9,000	151,000	192,000	19,500	211,500
Phoenix	18	3	21	272,000	24,000	35,000	331,000	28,000	359,000
Tucson	1	0	1	61,000	10,000	0	71,000	10,000	81,000
Portland	18	2	20	246,000	20,000	30,000	296,000	25,000	321,000
Headquarters	5	0	5	161,500	12,000	0	173,500	0	173,500
TOTAL	197	27	224	2,917,000	250,000	266,000	3,433,000	247,000	3,680,000

C. Organization of IHS and its Mental Health Programs

1. Area Organization

The services of IHS Mental Health Programs are delivered in the 17 western states, where the bulk of US Indian reservations is located. In about 1970 the South Eastern states, with three reservations (Choctaw at Philadelphia, Mississippi, Cherokee in North Carolina, and the Seminole/Micousukee in Florida) plus a number of non-federally recognized or serviced tribal groups formed the United South Eastern Tribes and contracted with USPHS for services. This gave closer local control and made programs more responsive to Eastern Tribal needs than when this group was attached to Oklahoma City Area for administrative purposes. Mental Health programs for USET formally began with fiscal 1974, and are not included in this report. It is recommended that they be visited and described separately as a future addendum.

The remaining territory is divided into 8 major Areas and two sub-Areas corresponding roughly to the BIA administrative agencies. (Each Area except Navajo is identified by the major city in which the Area office or headquarters is based.) These Areas and the regions for which they are administratively responsible are listed below and outlined on the map facing this text. The process of organizing a list of IHS Areas presents immediate problems. In IHS formal reports listing is most often alphabetical. This will be done in subsequent discussions in this report. However, in order to orient oneself, it seems useful first to use some geographic scheme, and the one selected has been to start with the far northwest, work across the northern tier, drop along the eastern boundary of the Mississippi River, and work back west again across the southern tier of states. (See map facing page 32.)

AREA OFFICE	STATES OR REGIONS INCLUDED
Anchorage, Alaska	Alaska
Portland, Oregon	Oregon, Washington and Idaho
Billings Montana	Montana, Wyoming, and Brigham City Indian School, Utah
Aberdeen, South Dakota	South Dakota, North Dakota, Nebraska, Iowa
*Bemidji Sub-Area	Minnesota, Wisconsin, Michigan
Oklahoma City, Oklahoma	Oklahoma, Kansas (also included USET - until 1970)
Albuquerque, New Mexico	All of New Mexico (except that portion lying within the Navajo Reservation) and extreme southern portion of Colorado and Utah known as the "4 Corners."
Window Rock, Arizona	The Navajo Reservation lying partly in New Mexico, partly in Utah and mainly in Arizona. Excluding the Hopi Reservation lying within its boundaries
Phoenix, Arizona	All of Arizona except the Navajo Reservation, but including the Hopi Reservation, Nevada, California and parts of Utah not allocated elsewhere.
Tucson, Arizona	The Papago Reservation, in southeastern Arizona serves as a model for the Health Systems Program Information Center, and as such has autonomy from the Phoenix Area Office.

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* Moving toward Area status, but under Aberdeen during the period covered by this report.

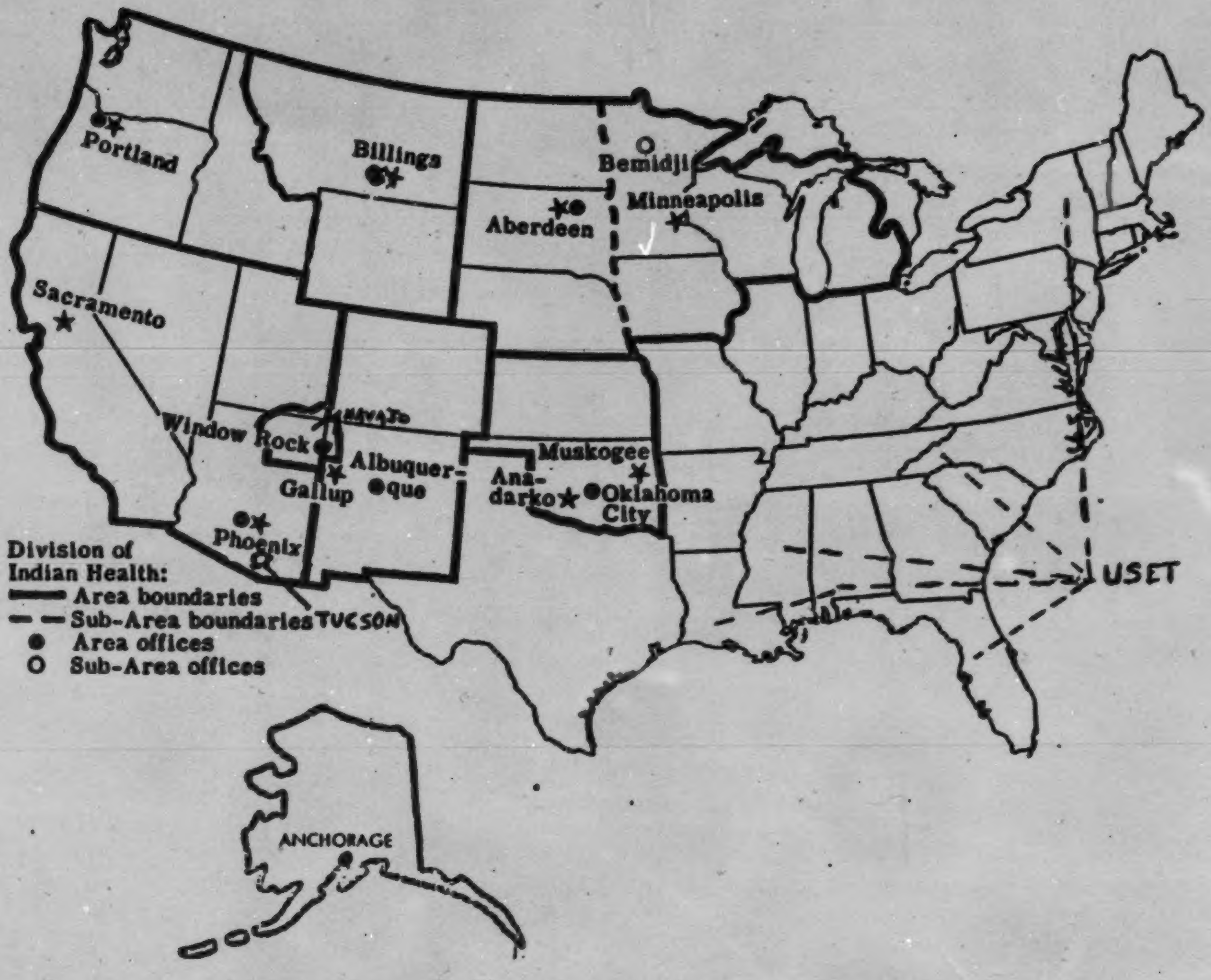
The headquarters city in each Area is usually, but not always, detached from any Service Unit. The outstanding exception is Anchorage, where the Alaska Native Hospital is a major Service Unit occupying adjacent buildings, and where there is from time to time a co-mingling of administrative and service duties. In some other locations the Area office coincides with the location of a major IHS facility, but is separate from it. For instance, in Albuquerque the Area offices are located downtown at some distance from the Indian Hospital, while the national headquarters for mental health is located in a small building on the hospital grounds but otherwise detached from both the Area and local Service Unit. In Phoenix the Area offices are in two locations within view of the Phoenix Indian Hospital, but separated by several blocks, and the Phoenix Area office staff do not have direct service responsibilities for hospital operation. In Portland, Aberdeen, Billings and Oklahoma City the location is a more or less central geographic point, where other federal and state or regional services also tend to aggregate, and which in some cases has a traditional relationship with at least some of the tribes being served. In these cases there are no IHS Hospitals within the city where the Area offices are located.

a. Area Advisory Board

The chief administrative officer in each Area is known familiarly as the IHAD (Indian Health Services Area Director) and is usually a physician. He has a staff of one or more deputy administrators and assistants for overall program planning and administration, personnel and fiscal duties. The Area office staff also includes the Chiefs of each of the specialty services: Nursing, Medicino, Environmental Health, Dentistry, Social Service and Mental Health Programs. The operations of the Area are now being scrutinized and supported or criticized

MAP SHOWING EIGHT IHS ADMINISTRATIVE AREAS

And Two Sub-Areas


Portland
Billings
Bemidji
Minneapolis
Aberdeen
Sacramento
NAVAJO
Window Rock
Albuquer-que
Gallup
Muskogee
Ana-darko
Oklahoma City
Phoenix
TUCSON
USET
ANCHORAGE
Division of Indian Health:
Area boundaries
Sub-Area boundaries
● Area offices
○ Sub-Area offices

by an Area Health Board made up of tribal representatives. This Board has advisory status and is assuming more and more responsibility for stimulating program development. The Area Boards also have liaison with a National IHS Advisory Board which takes a keen interest in Mental Health Program development.

b. Organization of an Area

Within each Area, services are delivered in various ways, through Service Units, which may be hospitals, clinics or health centers. Clinics are limited to outpatient services, and may be staffed for a complete range of services, or for only partial services or for part time. Health centers are often established in connection with BIA schools, for the purposes of caring for the health needs of pupils, and may also offer services to a local Indian population, usually on a limited basis. Occasionally health centers are established in relatively remote locations where full-scale clinic or hospital services are not justified, but where some form of local service on a part-time basis is needed.

Outreach programs are developed by the Health Educator and are also accomplished through the Community Health Worker, a para-professional position, filled by local members of the community generally considered employees of the tribe. These Community Health Workers serve as case finders, carry out aftercare and are utilized by the members of the community as a point of contact with IHS when they have medical and health needs. In Alaska, community health workers are trained at the Area Office in Anchorage. Most of the other Areas send their CHR's to the IHS Desert Willow Training Center near Tucson for training, but some local training programs exist. There is planned overlapping between CHR and Mental Health paraprofessionals in their training and in their functions at the local level.

c. Contract Services

Where specialized medical and surgical care is needed, beyond the ability of IHS staff to provide, contracts are negotiated through the Area Office with local medical service providers. With the exception of the Anchorage and Window Rock Areas, inpatient care for the mentally ill must always be so arranged, if what is needed exceeds the accommodation of the general hospitals of IHS. Phoenix and Oklahoma City Areas are considering development of IHS inpatient facilities.

Some specialized modalities of outpatient therapy are also contracted outside IHS, both to local mental health centers, other psychiatric facilities or in some instances to traditional medicine men serving the tribe.

Specialists serving as consultants to various programs may also be under contract to IHS. This is one fairly common way in which psychiatric consultation and back-up are provided to an otherwise multi-disciplinary mental health staff. Psychological testing may also be provided by consultants. Many of these consultants are professional personnel who have served a tour of duty with IHS. Following this they have opened private practices nearby or become affiliated with a mental health center or teaching institution in the region. The part-time consultation provides channels whereby their experience and expertise continues to be available even though they no longer have a full-time commitment to IHS.

The Chief of Mental Health Programs at each Area level was initially a psychiatrist, but in only two Areas; Anchorage and Albuquerque, does this still remain the case. In three Areas social workers have become Chiefs: Aberdeen, Oklahoma and Window Rock. In the other three, (Portland, Billings and Phoenix), nurses with either a Public Health or Psychiatric Nursing background or both are Chiefs of Mental Health Programs.

The responsibilities of the Area Chiefs of Mental Health Programs are individually defined as described in the reports on each Area. However, the duties of Area Chiefs generally fall into two broad categories: the provision of clinical back-up and consultation to Service Units, and administrative integration of the Mental Health Programs with the overall Area and national IHS programs. The Area Chiefs are in an administrative sense directly responsible to the IHAD, and call upon him for logistic support and local approval. Because of their separately appropriated budget and unique history, Mental Health Area Chiefs are also under administrative authority of the national Mental Health headquarters.

2. Headquarters: Albuquerque, New Mexico

The Indian Health Service as a whole has its national headquarters in Rockville, Maryland, a suburb of Washington, D.C. However, certain headquarters functions are located elsewhere such as: Tucson, Arizona (Systems Design and Research) and Albuquerque, New Mexico (Headquarters, Mental Health Programs) and Yakima, Washington (Social Work Associate Program).

Since the separation of Chief of Mental Health Programs from Area Mental Health Services occurred in the summer of 1973, it is still early to realistically appraise the effects of having a national headquarters for Mental Health programs, with a full-time staff to devote to overall planning and administration. However, it can be observed that the same permissive and encouraging atmosphere that initiated the IHS Mental Health Programs in relative autonomy has been carried on as official policy in the development of each Area program, within the constraints of budget and allowing for the cross-fertilization of exchanges between Area Chiefs at annual meetings.

In addition to the psychiatrist, the 73-74 staff includes a psychologist, two administrative specialists and a secretary. From time to time a management trainee or other specialist in training is given field experience in the Headquarters office. This headquarters staff provides some clinical consultation and back-up, programatic consultation, in-service and community training programs, and administrative and fiscal responsibilities for the Area Chiefs, as well as linkage between them and the other IHS headquarters personnel. The professional staff is engaged, at least for a large part of their time, in travel to the various Areas, both to familiarize themselves more particularly with the Area programs, problems and needs, and to provide services to the Area staffs. Participation in budget preparation, Congressional hearings, and other activities at the national level are also significant. The headquarters' personnel share with Area Chiefs in the recruitment of staff and the selection of personnel.

From the time Mental Health Programs were designated as a separate program in 1966 they have been headed by Robert Bergman, M.D., who also carried responsibility for the Navajo Area program until July, 1973. His basic philosophy and style of work is well covered in the Navajo Area Section of this report. A basic commitment to the development of the strengths of local resources within and outside of IHS, the coordination of IHS programs and staff in a manner supportive of and complementary to traditions of the culture of the tribes involved, and a real commitment to the assumption of leadership and administrative authority by Indian and Native personnel have characterized Dr. Bergman's administration.

He was succeeded as Chief of the Navajo Area by Mrs. Ellouise DeGroat, a member of the Navajo tribe, when Area and Headquarters' functions were separated. As of July, 1975 Dr. Bergman will leave IHS after 10 years of active service, including the orientation of his successor, H.C. Townsley, M.D., a Chickasaw tribal member from Oklahoma.

Dr. Townsley has served IHS in the Oklahoma City Area as a psychiatric consultant both to the Tishomingo Service Unit and at the Area Office level, and has consulted to the Norton Sound Native Health Corporation and other units in Alaska. During the spring of 1975, he has worked closely with the headquarters Mental Health staff, visiting many Area and Service Unit Programs and familiarizing himself with aspects of the program as well as its specific needs.

Both Dr. Townsley and Dr. Bergman have been active on the Task Force on American Indian Affairs of the American Psychiatric Association. In addition, Dr. Townsley has served as a member of several projects concerning American Indian Mental Health under NIMH auspices and is a member of the Review Committee of the Center for Minority Group Mental Health Problems of NIMH.

Working closely with the Chief of Mental Health Programs has been Mrs. Evelyn Hampton. Mrs. Hampton first became associated with IHS Mental Health Programs as a member of the ward staff when the inpatient program was initiated at Gallup Indian Medical Center. Her administrative skills were recognized and she became Dr. Bergman's Executive Assistant while he was still combining national program responsibilities with operation of the Navajo Area MH program in Window Rock. When the national headquarters for Mental Health was moved to Albuquerque, Ms. Hampton relocated there, aiding greatly in effecting a smooth transition.

Ms. Hampton has also continued to be interested in developing her clinical skills and on occasion serves as a co-therapist with headquarters staff as well as working under their supervision in a clinical capacity.

George Goldstein, PhD, has been associated with IHS since 1971, and began his Mental Health headquarters activities at Window Rock. His particular fields of expertise are in research and personnel training program development. He has been active in organizing and leading in-service training programs in many Areas, with special emphasis on training designed for Mental Health Workers, and for tribal and IHS Community Health Representatives, Alcoholism Counselors and Community Action Groups. He is particularly interested in securing academic recognition for IHS trainees.

Dr. Goldstein serves as Project Officer for a number of IHS evaluation contracts and is active as a consultant in many research projects, as well as to Area and Service Unit staffs. He has served since 1973 as co-chairman of the IHS Data Committee during the period of implementation and revision of the Problem Oriented Patient Record form. He is responsible for distribution and interpretation of the quarterly and annual reports based on these records prepared by the Albuquerque Computer Center.

Emmanuel Moran, an Oglala Sioux tribal member, has completed MA and other advanced graduate study with the Indian Education Program at Harvard University. His Mental Health headquarters duties since 1972 have been largely in the areas of personnel and finance. In addition to monitoring Area and national budgets for IHS Mental Health he is concerned with personnel problems and advises concerning recruitment and mobility of all levels of staff. His background also fits him for organizing and leading in-service training programs at the Area and national level.

Both Mr. Moran and Dr. Goldstein are often utilized as "troubleshooters", traveling to any unit of IHS as a representative of the Mental Health Program, thus multiplying the effectiveness of headquarters liaison. Together with Dr. Bergman, they make up a team which provides clinical, consultative, training, research and administrative resources to all Area Chiefs of Mental Health.

The fifth member of the headquarters staff is its secretary, Mrs. Kay Westby, another long term IHS staff member. Mrs. Westby had close associations with the development of the Navajo Area Mental Health Program, and as she became more specialized in the national responsibilities it was natural for her to move with the others to Albuquerque when the separate headquarters was established. Her personal knowledge of details of historical events and of personnel provide an invaluable resource for maintaining continuity through attention to details in implementing headquarters staff decisions.

The functions of this national headquarters for Mental Health Programs within IHS can probably best be summarized under the following five categories:

1) To act as national spokespersons for the program in matters of fund-raising, developing legislation and budget, and in relation to other national Indian organizations.

2) To provide program and training consultation to the Areas and their individual Service Unit programs.

3) To aid in the shift from a rapidly expanding program to one which settles down to a productive settled growth phase by coordinating policies for personnel, funding, and program development.

4) To begin analysing and synthesizing the programs so that one or more models developed and tested in the various Areas can be stabilized and established, with goals for the future.

5) To stimulate the development of evaluation and self-evaluation programs.

6) In addition, the clinical personnel attached to the national or headquarters unit are available for clinical consultation and service to a limited number of cases where this is appropriate and within their geographic range.

III. ACCOMPLISHMENTS OF THE IHS MENTAL HEALTH PROGRAM AS A WHOLE

A. Congressional Views

In the fall of 1974 and the spring of 1975 the Senate held hearings on a bill entitled INDIAN HEALTH CARE IMPROVEMENT ACT (S522) which was designed to diminish the gap between goals of IHS and what could actually be accomplished with the level of funding and the legal organization imposed during its first 20 years of existence. In the section of the Senate report on the bill, the paragraphs on needs in mental health offer a succinct summary and are quoted in full:

> Mental Health
>
> Poverty, forced abandonment of traditional ways of life, inadequate schools, degradation of Indian family life, and a harsh physical environment are elements of a situation in which many American Indians are frustrated in their attempts to live self-respecting, productive lives and, in some cases, in despair and anger, feel a need to lash out in self-destructive ways. The results of these conditions are seen in the form of excessive use of alcohol, suicide, violence, family disorganization, and neglect of children. Recognizing that these elements had combined to produce a large variety of mental health problems in young and old, the Congress established a mental health program for Indians in 1966. The Indian Health Service is now able to provide a few essential mental health services in some communities, including psychotherapy in languages such as Navajo and Lakota and group and individual consultation with Indian school children, alcoholics, and Indian community agencies.
>
> These services are still unavailable to many Indian people because funds have not yet been made available to provide for the full development of Indian Health Service mental health activities in all areas. The modestly funded mental health program has done little more than demonstrate what can be done and how to plan for necessary future expansion should the necessary financing be forthcoming. (Indian Health Care Improvement Act, Report of the Committee on Interior and Insular Affairs United States Senate together with Additional Views to accompany S. 522, May 13, 1975, U.S. Government Printing Office, Washington, D.C., p. 80)

While the last sentence seems to belittle what has been done in the development of these programs through its use of the phrase 'has done little more than' the two following clauses are an impressive accomplishment record indeed.

The general faith in what has been demonstrated by Mental Health Programs is operational in the language of the bill itself (S522 & H2528) which would provide for funds in addition to current regular appropriations (in section 201 (c)) for the following mental health services over a 7 year period (201 (c) (4), p. 18)

A. Community Mental Health Services

B. Inpatient Mental Health Services

C. Model Dormitory Mental Health Services

D. Therapeutic and Residential Treatment Centers for Indian Children

E. Training of Traditional Indian Practitioners in Mental Health

B. Specific Accomplishments of Mental Health Programs

These five types of programs have been developed well enough and established in one or more Areas with sufficient success that they can define the parameters of success and accomplishments of the IHS Mental Health Programs. Each is described in its details in the Area narratives, but can be succinctly summarized here.

1. Outpatient Programs — Community Mental Health Services

This phrase includes psychiatric services, but is broad enough to include all forms of outpatient mental health programs. The issue of whether to organize the services strictly as a medical specialty service or to include other programs was debated in the AAIA conference in 1964. There is still strong pressure in some localities to define Mental Health in psychiatric specialty terms, although in no Area has it been so limited.

The strong physician dominance of IHS is reflected in the initial selection of three psychiatrists to implement the first programs, and in the continuing recognition of the need for psychiatric services for the actuely and chronically mentally ill. The roles of the Nurse and Social Worker as medical auxilliaries were conceived by many of the IHS physicians as sufficient to carry out supportive, educational and preventive programs.

However, strong voices in the Indian community objected to the delivery of such precious talents only to those already defective, disabled or deviant when it was felt that the wisdom and skill embodied in a comprehensive Mental Health program could be deployed to the aid and advantage of a majority of the population.

This demand was one to which the modern mental health professional could resonate, and to which each of the psychiatrists chosen as first Area Chiefs of IHS Mental Health Programs responded. The early reports in each Area reflect the stress of the dual demands and needs — consultation, and direct clinical services — some speak frankly of the draining energy of continuous requests for crisis intervention and emergency room duties, while others merely reflect a schedule of activity that seems incredible when one attempts to place it within the time frame of 24 hour days.

A balancing of this equasion in different proportions is part of the differential history of the development of Mental Health Programs in each Area. Perhaps the only Area in which the psychiatrist-chief opted for a fully clinical role for himself was Albuquerque. Even there awareness of other needs was apparent in his permissiveness of administration which allowed other staff to develop their own styles of program and service definitions. In Portland Area the balance was struck over time with an emphasis on consultation and the development of state and local resources for direct clinical services. At Pine Ridge the psychiatrist strove for balance, with some greater emphasis on his own clinical activities to offset the research orientation of the overall program design. On the Navajo Reservation the initial one man staff was in a position to limit the "overseeing" of the program and to develop both forms of service in a coordinated fashion. The Navajo emphasis on training and respect for traditional healing and indigenous paraprofessionals maintained this balance.

Eventually this tension has been resolved in most Areas by utilizing the scarce psychiatric resources for clinical rather than administrative tasks. The emphasis on preventive, community oriented and early treatment programs has allowed the other disciplines such as social work and psychology, as well as the paraprofessionals to assume appropriate status. Administrative roles are assigned in terms of the personal interests and capacities of staff.

No Area program would be successful if it did not provide this well-rounded community service of consultation, education, training for other agencies, and facilitation of community-based efforts at prevention of serious emotional problems. The medical and clinical services needed by the seriously disturbed are seen as part of a total program, and not as an isolated specialty service.

Through contracts with local agencies and professional persons, as well as by IHS staff, all the elements required of Comprehensive Community Health Centers have been provided in each Area. The distribution of these services so that they can be readily available to all Indians is possible, providing funds and time to work in partnership with local communities is made available.

2. In-Patient Programs

There are only two in-patient wards out of the more than 90 Service Unit programs of IHS Mental Health Program services. These two are located in Gallup, New Mexico, and in Anchorage, Alaska, where each occupies a wing of the IHS general Hospital serving the Area in which they are located. In all the other settings, if a patient requires hospitalization, one or the other of two options is used. The first option is a bed in the general medical service. This is helpful for short-term crises, especially around depression and detoxification, but cannot easily be utilized for violent, manic, or chronic cases. The second option is the private, state or community mental health system which would be utilized by non-Indian patients. The use of the state and Community Mental Health Centers is, of course, in keeping with the general drive to develop service networks, and to create a climate locally where Indian peoples can become a part of the surrounding community.

This can work fairly well in a place like Oklahoma with three state hospitals and several private facilities, as well as several complete Community Health Centers not attached to state hospitals. Most of the Indian population of Oklahoma lives as close to an appropriate State or Community institution as they may to a medical facility of IHS. There is a waxing and waning of staff interest in Oklahoma State Hospitals in the particular and peculiar needs of Indian patients, and a variable level of services available, but there is some concern in each institution and within the State Department of Mental Health, which operates 17 county-based guidance clinics. Linkage with the IHS Mental Health Programs is at least theoretically possible in Oklahoma. One factor effecting the probability of development of state interests along these lines is the fact that the only two psychiatric nurses with Masters

Degrees in the Oklahoma Department of Mental Health are both American Indians, and both are keenly interested in developing special services and recruiting and training Indian staffs.

However, in other states there may be gulfs not only of physical distance, but of emotional distance as well. Arizona, for instance, demands full payment of costs from IHS for any Indian patients. The $80.00 per diem seems to be a formal acting out of the general attitude of exclusion and separatism that persists in many forms throughout that state's mainstream population. The reservations are all at a distance from urban centers, and Phoenix Indian Hospital has found that referral to a private facility costs practically the same as the use of public facilities. The problem in effecting referrals to this particular institution is to match patients to its traditional, insight-oriented therapy model. Plans to supplement this contract service by developing an inpatient facility have been under discussion in the Phoenix Area for some time, but budget and administration problems have not been solved.

These two states are singled out as examples of the extreme ranges found throughout the 17 states served by IHS. Most have similar problems, especially those of maintaining program linkages and follow-up coordination.

The problems of preserving family and therapeutic links with persons sent away to institutions is not a new one for IHS. In 1903 the BIA established the hospital at Canton, South Dakota, as a separate one for the Indian mentally ill from all areas. By 1929, it was overcrowded, and a critical report from a psychiatrist from St. Elizabeth's Hospital in Washington, D.C., led to an attempt to place the inmates in the state hospitals appropriate to their place of origin. By 1933, there were 80 Indian patients still unplaced who were transferred to

St. Elizabeth's Hospital. In the late 60's these patients, or the few who were still surviving, were "re-discovered", and returned for local care. Many of them had died far from home without being able to talk with anyone in their own language and knowing little or no English. A few suriviors are still to be found, especially in the Aberdeen Area, but almost no history or family data is available that can facilitate reintegration into the community.

During the interim between 1930 and the present, the policy of paying contract funds for care in state or private hospitals was established and continues in Billings, Portland, Phoenix, Albuquerque, Oklahoma and other Areas, with mixed success. In New Mexico, the Albuquerque Area Office details one of its staff to make regular consultation and participatory visits to the state hospital, where Indian patients are admitted without being segregated as Indians. In many instances, the mental health technicians at Service Units make real efforts to keep in touch with patients being sent away, and to keep their families in contact, but travel funds are limited and strained to the breaking point if the hospital is at any great distance.

Some pressure for in-patient contract care is lifted by local tribal alcohol programs where these include detoxification and halfway house facilities. For example, on the Flathead Reservation, the tribal alcoholism program has a formal arrangement to use a local Hospital with four beds set aside for detoxification and the IHS psychiatrist acts as a consultant. However, not all alcoholism programs have this complete range of services. Many either rely on distant points for this service or the severely involved person requiring detoxification must be handled as part of the regular work load of the general IHS in-patient medical service.

These patients, the suicidally depressed, and the other severely disturbed, often complicate nursing routines and other services in the general hospital. Many IHS physicians and nurses are not specially trained to deliver the personal care and to make their relationships therapeutic to the psyche as well as the soma of their patients. The tendency is toward impatience with the dependency and the failure to assume personal responsibility that characterizes mentally disturbed persons. This attitude becomes especially visible once the crisis leading to emergency admission has passed.

This problem of incorporating the disturbed into a ward devoted to the ill and injured is a perpetual one for those mental health staff who hope to use short-term stays and to keep family and community ties as intact as possible. There is frustration and helplessness expressed by mental health staff as well as by the medical and surgical staffs in almost every instance.

The two rather different in-patient services that have developed during the first six years of IHS mental health program introduction have been described in the Navajo and Alaska sections of this report. In both cases, the introduction of in-patient care evolved out of an experienced need for concentrated therapeutic intervention for which local resources were not available, and for which state hospital facilities were either inaccesible or inappropriate.

In both settings, links with the community of origin and after-care follow-up become problems. In Gallup, this is partially solved by the utilization of Navajo personnel in a majority of staff positions, and by holding general Area-wide mental health in-service training meetings with some regularity. In Anchorage, consultation and collaboration seem directed through the Social Services branch, and indirectly to Mental Health through its focus on the support systems outside IHS, such as the Alaska State Mental Health system. As a part of the Anchorage Native Medical Center the in-patient ward functions relatively autonomously in relation to the overall Area Mental Health Program.

In both Gallup and Anchorage the needs of the medical staff of IHS had to be recognized especially as they reflect the incompatability of institutional delivery of professional care for medical and surgical crises and the tolerance for emotional disturbance which prevents patients from conforming easily to routines of nursing and ancillary support systems. As an interesting parallel to this, in both settings, the medical backgrounds of the psychiatrists in charge of the in-patient ward involves him in the operations of the hospital in ways that are not restricted to his medical specialty. In Gallup, this has taken the form of administrative responsibility for the operation of the hospital as a whole at the deputy level. In Anchorage, the psychiatrist performs staff duties of a general medical officer, especially in regard to taking turns at coverage of emergency room and on-call functions at night and over weekends. To what extent some such involvement validates the medical specialty of psychiatry, and to what extent participation in total hospital routines aids in gaining access to staff for consultation and other functions, has not been determined or evaluated. In both cases, the choice of activities has been the result of a combination of local needs and the personal inclinations and talents of the psychiatrist involved.

In Gallup the emphasis is on developing a treatment millieu with a rather democratic participation in the ongoing activities and planning for the unit. Highly individualized and often quite contrasting therapeutic plans evolve from the mutual interaction and relationships established between staff and patient. In Anchorage, the more traditional therapies, with a heavy medical orientation are practiced, although group interaction opportunities exist.

In Gallup funding for the in-patient ward is separate from the overall Area budget, and also from the hospital budget at this time. The in-patient unit therefore has a semi-autonomy which sometimes makes the boundaries of its operations indistinct to staff and observers alike. In Anchorage, the major budget responsibility for the operation of the ward lies with the hospital, and only the salaries of the psychiatrists are charged to the mental health unit at this time.

Both units need to be seen in the context of the total development of the Area Mental Health Program, and of the availability of a supporting network of services outside IHS as well as within it. If in-patient units emerge as a need of other Areas, it is probable that while the experience of these two units will be helpful during the planning stages, that neither represents a completely transposable ideal model for another context. The ultimate goal should be to interlock the special resources of IHS Mental Health Programs with the total pattern of resources available, so that each necessary component of a full range of services is available within a network, rather than competitive duplication. Equally important is avoidance of fragmenting scarce personnel or introducing discontinuities in the lives of the persons served.

However, the development of the in-patient service at Gallup and at Anchorage demonstrates that total hospitalization within the general Hospital settings provided by IHS is feasable. Such wards seem to be more effective in close liaison with the local resources than institutional treatment purchased outside the system in more remote institutions that are not adapted to the needs of Indian patients. Phoenix Indian Medical Center is developing plans to follow shortly in this activity, while Rapid City Indian Medical Center in Aberdeen Area is able to develop a similar program utilizing the general medical facilities without a special ward.

3. Model Dormitory

Under this heading IHS Mental Health Programs offers a possible solution to a very difficult problem. The creation of IHS in 1955 was due to the inability to resolve the difficulties of implementing good health care under the administrative control of a non-public health oriented agency such as the BIA. The only link to the former system which remained was the IHS charge to deliver services to the students at BIA Boarding Schools. In most instances the delivery of medical and surgical services has been fairly easily accomplished within the limits of funding available.

However, assistance with the severe mental health problems of students, and often of Indian staff and employees, has not so easily been offered and accepted. In part this is due to the very different goals of Mental Health and BIA staffs -- The BIA is focussed on operating a system of domicilary care and education, and feels that it requires help with making more manageable those pupils who cannot conform comfortably to the BIA program offered. If a mental health system fails in this, BIA expects its sanction for removing the disturbed and disturbing student.

The IHS Mental Health staff, with a preventive orientation, and with training in the effects of situational stress on behavior, have most often felt that many of the problems referred could be best resolved by changes in the system of Boarding School operations. One might at times wonder if one group (BIA) felt that deviant, depressed, and obstreperous students were the patients, while IHS Mental Health staff and consultants sometimes felt that the BIA school system itself was the patient.

A special grant to the Toyei BIA School administered through Dr. Bergman's office while he was stationed at Window Rock, Arizona, demonstrated how a relatively simple system change could be effective. The basic grant provided more staff to be available as adults to the young children ages 5 through 9. The evaluation of the progress of the children in the Model Dormitory, as well as the monitoring of their needs for referral for special mental health care, demonstrated unequivocally that this simple system change, accompanied by some staff training in the needs of children, was tremendously effective in reducing the number and degree of emotional problems within the school. It also appeared to result in improved physical health and possible accelerated educational achievement. This model is recommended for multiplication with IHS Mental Health staff facilitation by everyone who has studied the results, and the Senate committee singled it out for special mention. If the recommendations are followed, it may be the first time after many such demonstrations by outside agencies that an effective Mental Health program for BIA Schools can be mounted. (See also Flandreau school studies 1964-67.)

4. Residential Treatment Facilities

As more and more public school facilities have become available to Indian children and youth, the use of the BIA Schools by tribal and local authorities has shifted. In some instances the population of the schools has dwindled, especially schools located at some distance from Indian population centers. Where school census has not dropped, the pupils enrolled have changed. Often the type of youngster sent is not the average youth needing an education, but one for whom a residential facility away from home, less punitive than reform school, would hopefully be socially and emotionally therapeutic.

In a few instances local IHS Mental Health staff have supported programs that have succeeded in providing group home facilities which short circuited the need for sending youth a long distance. The Papago Group homes in the Tucson sub-Area (Phoenix) and the Warm Springs (Portland Area) Program are both examples. In other instances the deployment of special staff and programs has enabled the BIA facility to shift its mission, as described in the section on the Alcoholism program at Chemawa (Portland Area chapter) and as seen in the efforts of the Alaska Area Office consultants at Mt. Edgecomb in Alaska. A formal recognition of this type of program, and its development either within the BIA facilities as a change of mission, or independently as a tribal and Area resource now seems possible. These models, developed by or with much support from Mental Health Program staff can be duplicated elsewhere.

5. Training Traditional Indian Practicioners

The outstanding program of this type has been the Navajo Medicine Man Project, funded through NIMH with IHS staff contributions. It is quite clear that the training is a two way process. The traditional Indian practicioners are able to incorporate Community Mental Health practices and orthodox psychiatric methods into their own range of services. They are also able to offer much to IHS staff. Shared learning leads to positive relationships between IHS and traditional healers.

Although not all tribes have a reservoir of traditional practicioners as resources, a number of others besides the Navajo have expressed an interest in developing a cooperative training program.

C. Additional General Accomplishments of Mental Health Programs

1. Involvement of Indian and Alaska Native Peoples

There is no longer any issue over involvement of Indian people in the planning and execution of their own mental health programs.

a. Through formal means such as advisory boards at the Service Unit, Area, and national level this is being done. The Navajo, Alaska, and Oklahoma Health Boards have taken particular interest in the development of Mental Health Programs, as has the National Indian Advisory Board.

b. All the paraprofessionals employed by IHS Mental Health are community people, knowledgeable of their own culture and of local needs. Two of these, Gayla Twiss at Pine Ridge and Celia Rohrbuck at Rapid City, have Service Unit responsibilities.

The number of Indian professionals involved has been steadily increasing, and is in part limited by the small numbers available. However, both at the Area and national leadership levels, Indian professionals are involved in the administration of IHS Mental Health Programs, and as more trained persons become available, it is formally acknowledged that they will be utilized.

2. Career Lattice and Training Planning

Training programs and Career Lattices are being developed which give realistic hope of implementing these affirmative action goals within the IHS Mental Health Programs on an ever-broadening base. Navajo and Billings Areas have developed outstanding training programs. There has been the beginnings of the development of a training center for Mental Health at Desert Willow (Phoenix). Aberdeen has been conscientiously involved in career ladder development.

3. Residency Training for Psychiatrists

An important area of training, that of professionals, should be noted. Particularly successful have been the involvement of Residency training programs in the training and staff selection of applicants for professional positions with IHS. (See Billings and Portland Areas) To some extent a similar provision for field placement of Social Work students has been utilized. However, this model has not been applied to psychologists or other mental health disciplines in any really systematic fashion. It appears to be a most profitable recruitment, initial orientation and training framework, and to have more potential than has presently been developed for providing a regular flow of qualified and appropriate personnel for IHS Mental Health Programs.

4. Computerized Patient Records

Another aspect of mental health services not mentioned in the Congressional report has been the development of a computerized patient problem-oriented record form, utilized by both Mental Health and Social Services. This innovation in record keeping permits quarterly and annual reports of the activities of staff to be made in terms that can be readily understood by both advisory boards and IHS staff. The pilot work on this project was initiated for Mental Health Programs under James Shore, M.D., in the Portland Area, and was pilot tested in Oklahoma and elsewhere. Coordination with parallel efforts of the Social Service Branch resulted in a mutually agreed upon form and procedure introduced throughout IHS in the summer of 1973.

A Data Committee, co-chaired by George Goldstein of Mental Health Programs Headquarters and Vesta Starkey, MS, Albuquerque Area Social Services Branch Chief, has met several times a year to monitor the results and make needed revisions. The committee includes professional and paraprofessional representation from all geographic regions and models of service delivery. One analysis of the first year's data accumulated through this computerized record will be the subject of a report supplementing this one, and should be available during fiscal year 76.

All of these add up to an impressive list of accomplishments as well as fleshing out the skeletal framework of the program outlined in the preceding budget summaries. In many dimensions they give substance to the hopes projected by those who planned for IHS implementation of Mental Health Services in 1964 and before. Given the brief time span of less than ten years, and the deployment of sites of service delivery over 17 states, and to more than 135 tribal groups at over 90 Service Units, it is an objective record in which IHS can take great pride.

IV. ISSUES YET TO BE RESOLVED AND RECOMMENDATIONS

In spite of these major accomplishments, many of the issues foreshadowed from the earliest discussions of mental health programs within the IHS remain unresolved. Some new and specific issues have also come to light with these first years of experience in implementing mental health programs for Indian and Alaska Natives. In presenting a discussion of these issues there will be a deviation from the format employed in each of the Area narratives. At the end of each Area narrative the problems yet to be resolved that had been identified by this staff were merely briefly described without recommendations. In this final summary however, some effort at recommending solutions, or at least suggesting the direction in which one might turn to discover solutions to these unresolved issues will also be stated.

In some ways this action may mark the point at which pure narrative description ends, and the evaluative studies begin. As such, however, these recommendations should not be interpreted as final declarations of criteria of success or failure of the mission of IHS mental health program development. Instead they may be taken with the record of accomplishments as the high and low water marks along the channels to be navigated in the next decade.

A. Service Delivery and Program Development

The first group of issues and recommendations relate to problems of Mental Health service delivery and program development.

1. Need for Epidemiologic Data

Epidemiologic data is needed to define the dimensions and scope of Mental Health needs of the Indian population served by IHS. The lack of epidemiologic studies was a part of the concern of those who discussed the addition of preventive and treatment mental health services prior to the initiation of such programs. Many of the headquarters IHS staff aruged that the needs were so glaringly obvious that treatment facilities should begin to be organized on an emergency basis as was done in the provision of other medical and Public Health services. This, in fact, became the official action, with only the Pine Ridge program having a budget and plan for in depth studies to identify both treatment and preventative needs.

In almost every Area the first psychiatrist assigned made an analysis of his caseload during the initial year of his tour of duty. However, as the increased demand for new services cut into the amount of time available for research, this activity was dropped and usually no further data was collected until the introduction of the standardized reporting form in 1974. A few studies of reservation populations were made either by IHS staff or in cooperation with University training programs and medical schools. Where retrievable, all of these records have been incorporated into the Area narratives, and can be located in the index.

In no instance, other than at Pine Ridge and on the Makah Reservation, has an epidemiologic survey of an entire Indian population been made. All data, even the current computerized patient records, is based on the patterns of utilization of IHS services. Generalizations are therefore extrapolations of these data to the Indian population as a whole without being able to test the reality of actual need, or knowing what is being satisfied through non-IHS facilities.

The magnitude of the task of even doing an epidemiologic survey, based upon a stratified sampling of the Indian population, staggers the imagination.

The definition and measurement of need for preventive services, so very much a part of the ethos of Public Health, is a difficult enough task in the case of infectious diseases. These tasks have not been accomplished for any population in a manner that provides clear outlines of the needs for mental health services. Indeed the definition of mental health services themselves has not been agreed upon except at a highly abstract level.

a. Need for Tribal and Community Participation

In conducting such an epidemiologic study, the Indian and Alaska Native population must be involved in a number of ways. It is self evident that some interpreters or translaters will be needed if all strata of the population are to be reached by the surveyors. As a matter of fact, indigenous interviewers are known to be more effective at eliciting information and are accurate reporters if they are well oriented to the task and trained in its technical aspects.

It is also important in the design and adaptation of the survey instruments that local tribal persons contribute their knowledge of the culture. Often there are specific syndromes within a culture that do not fit standard psychiatric classifications. Arctic Hysteria, Salish Spirit Sickness and Navajo Ghost afflictions are three well known examples, and there are undoubtedly others.

b. Need for Appropriate Survey Tools

While some suitable instruments for differentiating those in need of psychiatric care have been validated cross culturally, these instruments do not always define the population vulnerable to the particular stresses of the Indian community. It is not clear whether they will identify those who have not yet developed conventional neurotic or psychotic tendencies. It may be necessary to adopt or develop new instruments and validate them in the process of securing the needed data.

Local Indian and Native leaders also often know of the unsuspected presence of psychotic individuals. William Nichols at Warm Springs, Oregon relat how after several years of developing programs along lines designed by the tribe, he began a search for the mentally ill who might be treated. Once his interest was known a number of such individuals were pointed out, for whom no one in the tribe felt there was any help. Therefore, they had not previously been identified.

In addition to these rather obvious reasons for utilizing indigenous staff, there is an even more important justification. In the long run, the goals include Indian direction and participation in Mental Health Program development. It is far better to involve local leaders at the data gathering stage, so that they as well as IHS staff feel a sense of participatory ownership of the results. There is a need for tribal leaders to have not only a sense of responsibility for completeness and accuracy, but also an investment in the recommendations that follow from the fact-finding. If partnership in the implementation of recommendations is expected, partnership should precede the formulation of policy and decisions.

c. Protection of Human Rights

One word of caution should control, but not dampen enthusiasm for this project.. Much is being done formally to insure the protection of individuals who have previously been studied without respect for their privacy, or consideration of the impact of research on their lives. Sensitive Behavioral Scientists are aware that this area of investigation is a delicate one.

For example, a somewhat premature extrapolation of data from a few tribes led to the promulgation of the notion that most tribes had suicide epidemics. It is now known that this self destructive pattern is limited to a few tribes, and most probably to a selective group of families within those tribes. While this information is of great value in planning Mental Health programs, it is not clear how to disseminate it without labeling tribes and families as suicide prone. To so identify the vulnerable might well produce a climate conducive to a self fulfilling prophecy of doom for some Indians.

A careful epidemiologic study must plan within those ethical standards which will protect individuals, families, communities and tribes from scapegoating, stereotyping or exploitation.

d. Utilization of Data

Too often there has been a failure to integrate epidemiological data into service planning. This has been true for Mental Health Programs in general, not just those in IHS. We might mention the Fort Hall Suicide Prevention Program and the Chemawa Indian Boarding School Alcohol Abuse Program as two special cases where epidemiological data was in fact used for planning purposes.

RECOMMENDATIONS:

3. Tribal and Alaska Native leaders and personnel should be involved at all stages of the development of any epidemiologic survey.

4. That IHS continue to develop and examine its data relevant to the patterns of utilization of mental health services. This is the best treatment prevalance data available.

5. In doing this it is imperative that IHS begin to budget time and personnel, or to consider contractual negotiations, for the development of a plan for an epidemiological survey based not only upon the incidence and prevalance of mental illness among the American Indian populations, but also based upon the best definitions available for preventive mental health needs and services.

6. Such surveys should be reported not only in terms that are national and Area-wide, but also should be sensitive to differences in tribal situations and cultures. They should reflect the strengths of these cultures as well as their vulnerabilities.

7. Careful consideration of ethical standards in conducting research that involves human beings must control all decisions concerning the gathering and dissemination of this data.

8. Attention must be directed from the outset to the utilization of data once it has been collected. Planning and implementation of services must be integrated.

2. Adaptation and Integration of Mental Health Services with Traditional and Indigenous Cultures and Practices

It is probably fair to say that the success of Mental Health Programs varies with the degree of sensitivity to the local culture and its traditions. It some instances this sensitivity has found concrete expression in the development of programs.

For example, two Areas, Navajo and Phoenix, have official regulations governing relationships with traditional healers and Medicine Men from their constituent Indian populations. In both Areas the legitimacy of these services is recognized for those who desire them and find them appropriate. This permits some reimbursement of family expenses for travel, and other activities required in arranging for the ministrations of traditional healers. It also permits the paying of consultation fees on the same basis as these are paid to other specialists. Although it is not clear that the dollar amounts paid are in equity with those paid for medical consultations, it does appear that they have generally been negotiated within the prevailing economic system of the tribes involved.

In the Navajo Area there are also reciprocal arrangements for Medicine Men to participate in the training of IHS staff, and for IHS staff to participate as faculty in the School for Medicine Men based at Rough Rock Navajo Community School. This training program, now in its 9th year has gained national recognition and is often referred to as "The Navajo Mental Health Program" by both Navajo and federal personnel. It is a distinctive feature of IHS integration in its Mental Health Programs of Indian medicine and indigenous cultural values.

In the other six IHS Areas, relationships are not so well formalized. There have been instances of cooperative recognition, and also of opposition to integration of the two systems by both Indian and non-Indian people. In the Albuquerque Area, for instance, the Pueblo peoples are staunch advocates of independence and autonomy and prefer mutual respect for their traditions of healing, but at a distance, and without formal sanctions or mutuality of exchange.

The Mental Health staff generally have operated within this context, and respected their desire and right to privacy in these matters. Some support for utilization of the alternative system is afforded, but active participation of professional staff and official policy usually stops short of specific individual referral.

In the Anchorage Area several interesting relationships have developed between individual Eskimo or Indian healers and individual IHS staff. These seem to be very personal, and sometimes very fragile shadows if the spotlight of official attention is turned upon them. This may be due to distrust, but is more likely a natural avoidance of exploitation as exotic curiosities by sometimes well meaning but obtuse non-Native inquirers.

Similar reluctance may operate to suppress official notice of the activity of traditional healers in the Portland, Billings, Aberdeen and Oklahoma Areas. It is known that in some instances tribal cultures have been fragmented, and in other instances the well meant energy of missionaries in suppressing paganism has driven well underground any acknowledgement of the existence and persistence of traditional practices. Not all IHS staff have trust in traditional beliefs, nor can they easily develop collegial relationships with other disciplines within the modern US mental health field, let alone with its practitioners from outside their own culture. Such staff are persons of utmost integrity, and of humanistic motivation, but they remain skeptical or even openly opposed to the perpetuation of what they consider un-scientific.

Even more complex is the attitude of the Indian population as a whole. Many, the products of several generations of cross cultural influence, have adopted the attitudes of Christian missionaries and a scientific orientation toward health and medicine. They see the subsidization and sanction of traditional healers and Medicine Men as a step backward along a road they and their families have painfully traveled. An official policy of the sort utilized in the Phoenix and Navajo Areas would, and has, called forth vociferous opposition, more vigorous from the Indian community represented by this large segment, than from the white community represented by federal agencies and legislation. Often within an Area some tribes will be offended by the recognition of traditional healers, while others would welcome the opportunity for free choice and collaboration.

Other program examples are the Children's Group Home in Warm Springs and the Cheyenne-Arapahoe Alcohol Rehabilitation Center at Bessie, Oklahoma. Part of the success of the group home program is that it can be seen as a modern-day equivalent of a traditional practice -- the "Whipper Man" who was a disciplinarian for wayward youth. The alcohol rehabilitation program, which was originally funded by IHS, presented a unique blend of Indian culture, Native American Church, Alcoholics Anonymous and mental health concepts and practice.

RECOMMENDATIONS:

9. That the official policy of IHS toward traditional healers and medicine men be permissive of the development of contractual arrangements as presently utilized in the Navajo and Phoenix Areas, but that it leave the development of such relationships to the direction of local tribal advisory boards and permit discretion to be exercized by staff at the Service Unit level.

10. That an effort be made in all Areas to recognize both the constraints which local cultures impose and the opportunities they provide for creative approaches to the provision of mental health services.

3. Balance Between Direct and Indirect Mental Health Services.

It is apparent that the optimally functioning program for mental health within IHS has attained a balance between the delivery of appropriate care to the acutely and chronically mentally ill, and consultation to community agencies. This is closely related to other issues but needs specific address, since there exists a polarity within the field of community mental health, affecting all disciplines, between the delivery of indirect and direct services.

The Area chapters describe the imbalances of services which occurred:

In the Billings Area under Dr. Gustafson;

In the Albuquerque Area where tensions between Dr. Davis and Dr. Andre over this issue resulted in fragmentation of the staff and a laissez faire policy;

And in the Aberdeen Area where involvement in the community may mean the risk of loss of professional status at a minimum and of one's life at maximum during the times local issues boil over into physical confrontation.

One sees many examples of efforts by administrators to control activities without achieving a balance. In each of the Areas cited above, other staff, at other times, have presented examples of outstandingly balanced programs.

In the Billings Area for instance, the psychotherapy initiated by Dr. Barter's residents and of Tom Keast, MSW, on the Crow and Northern Cheyenne has persisted in spite of its being ignored or disapproved temporarily. Under Ms. Tower a balance is being struck in many other places throughout the Area. In

Albuquerque Area the programs at St. Catherine's School and at Zuni seem to have stabilized around an optimal balance of clinical service and consultation. In the Aberdeen Area the Rapid City program has had a high investment in community organization and consultation as well as direct clinical services. In addition, tribally sponsored programs at Warm Springs and Sells (Papago) and most of the Navajo programs seem to have achieved the resolution of this problem to a high degree.

The problem of clinical services emphasis versus indirect consultative services and community involvement is not unique to IHS. It occurs throughout the Mental Health scene around the world. An emphasis on direct services results in a silting up of clinics with acute and chronic cases and eventually long waiting lists which negate the reason for their existence. Equally, an emphasis solely on a consultative, teaching, community organizing model makes no provisions for individuals or families for whom preventative and 'early' interventions by a wide variety of personnel come too late, prove insufficient, and for whom prompt clinical expertise and even hospitalization may be required.

Part of the difficulty lies in the fact that mental health personnel in all the disciplines and occupations come with a variety of talents, preferences, and skills. A degree, graduation from a training program, or acceptability to the tribal council does not provide interchangeable people to staff programs. At the present time there are many indications that IHS Mental Health Programs are understaffed if they are to do an adequate job of meeting needs in either direct or indirect services. Consequently it has been difficult to demand that staff meet both sets of needs. Possibly a reluctance to face this issue, which seems outside the realm of those responible for program development, has obscured the need to identify and describe the balance desired.

RECOMMENDATIONS:

11. The IHS Mental Health staff needs to develop a multiple activity definition of its services that will include those tasks which are common to all occupations within the staff and those which must legally or for other reasons be reserved to one or another discipline.

12. The IHS staff as a whole needs to have sufficient orientation to the usefullness and limitations of mental health services that it will request and refer these services appropriately. A planned in-service program should be constructed that has official support in the form of sanction for time and approval of mutually developed changes in the service delivery systems where these will prove more effective and more adaptable as well as more acceptable to the Indian clientele.

13. That the achieving of a balance of indirect and direct services, rather than choosing one or the other, be considered as the primary mission of Mental Health Programs.

14. That adequate staff and budget be sought to achieve this balance in all Areas.

4. Mental Health Consultation Activities to Other IHS Staff

As will be noted in each of the Area narratives there is a tabulation of the agencies with whom Mental Health staff consult. In all Areas the bulk of consultations take place between IHS staffs. Mental Health staff talk with the physicians, nurses, Maternal and Child Health, sanitarians, etc. The majority of these contacts are patient oriented. A high proportion of in-house utilization is not surprising since many IHS staff consider mental health a medical specialty and the model of referral and consultation from medical practice could be presumed to prevail. IHS Mental Health staff, whether physicians or not, participate in Doctors' rounds and otherwise function as part of both the inpatient and outpatient staffs at a number of Service Units. However, their special expertise extends to the potential adaptation of medical treatments and nursing care to the cultural and personal needs of patients. These characteristics, as well as the skills in dealing with normally anxiety provoking situations affecting both patients and staffs have a high potential for in service training and program development as well as individual patient care.

However, it is a frequent comment in the interviews as well as in narratives submitted by staff, that Mental Health staff feel that they are peripheral to the operations of the hospitals and clinics. They often report that only when physicians and nurses wish to 'unload' troublesome or chronic patients do MH staff get called in or receive referrals. A persistent characteristic of reports is that there is no time for staff conferences or for reporting back their findings and recommendations in an orderly manner. In many cases this appears to outside observers to be an inefficient use of highly technical expertise of Mental Health staff. In some instances this behavior becomes self defeating on the part of general IHS staff who never have time to solve problems but are always dealing in crises.

RECOMMENDATIONS:

15. That IHS administrators think through the potential for mental health contributions to inservice training and for regularly scheduled IHS case conferences. Administrative support for internal consultation on a more orderly basis would probably result in considerable increase in efficiency.

5. Mental Health Consultation to Agencies External to IHS

Each Area Mental Health staff reports a wide variety of other agency consultation contacts — Welfare, corrections and courts, schools and tribal organizations usually predominate. However, these contacts also tend to be case or patient oriented most of the time and to occur on an unplanned and unscheduled basis. There are very few regularly scheduled consultation opportunities, either case oriented or programmatic in content. This means that the Mental Health staffs are never able to plan their work systematically within the community, but must rely on chance opportunities to develop relationships and referral resources.

Many Mental Health Staff describe ways they have tried to solve the problems involved in establishing more regularity in their schedules for contacts with IHS staff, whom they see frequently. There does not seem to have been a corresponding amount of energy spent in attempting to formalize and regularize contacts with external agencies. Both situations appear to be inefficent. Both may be a function of inadequate personnel to allow specialization in program consultation and the development of expertise in using case conferences as community relationship tools. Both Mental Health and other IHS staff are often spread very thin and are hard pressed to make any changes in routines established to deal with a large volume of patients, many crises, sometimes inadequate buildings and equipment, to say nothing of travel over long distances.

RECOMMENDATIONS:

16. That IHS Mental Health staff receive some further inservice training in consultation techniques and the development of inter-agency relationships

17. That as has been indicated elsewhere, a realistic appraisal of staffing needs be made, and efforts to budget appropriately be strenuously pursued.

6. The Development of Services for Special Populations

a. Children

Services to young children tend to be sporadically dispersed throughout IHS Mental Health Programs. In part the focus on this age group depends upon the activities of other programs such as Maternal and Child Health within IHS and Headstart and Daycare outside of IHS. It may also depend upon the training and interests of staff, and the accidents of happy allocation of persons with expertise in children's work to locations that are interested, ready or need such services. This is a haphazard development, which is probably typical of an early growth in program development. It also reflects the philosophy of assigning staff to a location without real knowledge of the particular needs of the population to be served or of the skills and interests of the personnel. This is characteristic in times of staff shortages, but need not be made a permanent personnel policy.

It is known that 50% of the Indian population is under the age of 20. Most of this younger half is below the age of adolescence. Therefore, there is a real need for the development of children's and family services across a wide spectrum. Serious problems of teenagers and young adults may not be completely prevented by earlier attention to children's needs, but it is certain that many later problems will be aggravated and escalated for lack of appropriate early attention.

Where personnel with special training, skills, and interest in children have been part of the staff, outstanding children's services have been developed.

In Alaska the school consultation and child evaluation programs of Barbara Nachman, Ph.D., and Barbara Doakes, both exceptional child psychologists, have been successful. In Pine Ridge the balance achieved first by Dr. Carl Mindell, a child psychiatrist, was followed by the work of Gilbert Voyatt under an independent research grant. Gayla Twiss secured additional training and has provided continuous school consultations of a high degree of effectiveness, particularly around elementary school learning disabilities. Albert Hiatt in Albuquerque Area, in cooperation with social workers and maternal and child health staffs, has developed an excellent preschool and follow through program for Zuni and other Pueblos.

RECOMMENDATIONS:

18. That personnel needs be planned for in terms of the need for specialists in work with children and youth, in family therapy, and in interagency network development in order that the present population explosion of young American Indians can be appropriately served.

19. While recognizing that all staff are not temperamentally suited to work with children and youth, nevertheless some staff training oriented toward the skills required should be included in training programs and Area and national meetings.

20. In-house exchange of information about particularly successful programs for children and youth should be widely stimulated and carried out. For example, the Group Home Program at Warm Springs, the Apache Youth Program in Arizona, the successful peer counseling program involving IHS and the School of Social Work at St. Catherine's School in Albuquerque Area, the Learning Disabilities Diagnostic and Prescriptive Teaching Program at Pine Ridge, and the successful cultural adaptations of teaching materials in Alaska should all be well known as models which other Areas and Service Units might adapt to their own needs.

b. Boarding School Youth

Both the Model Dorm project at Toyei and the alcoholism project at Chemawa in Portland Area are examples of inter-agency cooperation between the BIA-maintained Boarding Schools and Mental Health Programs of IHS. Unfortunately, Tuba City Boarding School is an example too — of what happens when there is a failure to coordinate these two agencies. In general, there is a lack of coordination and cooperation when it comes to Boarding Schools, and yet all of the above situations point to the fact that the youthful Boarding School population have special needs and problems which need to be recognized and evaluated, and of course, dealt with in a comprahensive form. The need for focus on Boarding Schools becomes obvious with the realization that none of the recommendations from the Flandreau project in South Dakota have been implemented to date.

RECOMMENDATION:

21. It was originally the contractors' understanding that the services to Boarding Schools, operated by the BIA, were sufficiently important, and sufficiently complex, that they would require a seperate contract for analysis and narrative description. It is hoped and recommended that the problems, programs, and potentials of the Indian Boarding Schools be the subject of a joint study sponsored by both BIA and IHS in the near future.

c. Aged

There is a real dearth of special programs for the elderly, although with the great respect that most tribes tender their older members this would have a high priority if tribal voices were heard. Over and above needed medical care and possible group home needs, there are emotional problems to be faced both by the younger generations and the elderly themselves. One example of a successful project is the White River Apache beadwork program, which involves the adults and children in constructive activities through the guidance clinic. This in turn generates, through sales of work, funds for family visiting and the provision of favorite foods for elders placed in nursing homes away from the reservation. Creative work in this area needs widespread attention.

RECOMMENDATION:

22. That each Service Unit and Area begin to think creatively about the needs of the elderly, and to involve themselves with appropriate tribal groups and agencies in such a way as to support the emotional needs and capitalize on the cultural strengths of the aged in the Indian population.

d. Families and Family Therapy

Nearly every report on Community Mental Health programs and practices emphasizes the effectiveness of working with distressed and disturbed individuals in their natural context and normal environment. For work with American Indian and Alaska Native peoples there is universal recognition within IHS Mental Health Programs that this "context" not only includes, but is often dominated by, families. The importance of the family and its extended form, the clan, is well documented in most descriptions of Indian culture. IHS Mental Health Program goals and descriptions pay considerable attention to the idea of working with families and of including family members as well as patients in programs and therapeutic work.

However, relatively few of the professional staff have had any training in family therapy and consequently most of the implementation of these good intentions falls short of the mark. Not all staff are as naive in this field as at one Service Unit where the staff proudly pushed forward their expert on working with families. The role, self described, consisted of seeing the patients in their own homes. However, since privacy was difficult to arrange, the sessions were usually held in the staff member's car -- and no family members were ever allowed to join in.

Some couples' therapy was seen in Alaska and workshops utilizing Family Therapy consultants have been held there and on the Navajo Reservation. In Oklahoma a few staff had attended family therapy workshops presented under the auspices of the State Health Department. Building largely on a base of Transactional Analysis, a few family groups were being seen in North Dakota and in the Billings Area. But they were the exception rather than the rule. The model of therapeutic relationships most often seen was a variation of one-to-one psychotherapy. Second most frequent was some form of group (peers) therapy.

Since there is a recognized branch of expertise known as family therapy with available resource persons, texts and journals, some effort to facilitate the acquisition of skills in this field seems essential if the emphasis so often mentioned is not to remain merely lip service to a good idea.

RECOMMENDATIONS:

23. Planning and implementing staff training in family therapy in each Area. This should be a series of workshops and theory sessions spread over one or two years, with some provision for supervision or consultation with trained family therapists willing to adopt their techniques to tribal cultures.

24. This training should be available to all levels of staff in all disciplines, since family therapy can be successfully conducted by paraprofessionals and by any of the mental health disciplines, provided they are willing to learn.

25. Some thought should be given to evaluative research which not only compares this type of intervention with others, but also establishes parameters of culturally dictated adaptations of technique and theory required in various IHS settings.

26. Information about family characteristics and the importance of family systems in facilitating appropriate treatment and preventive health measures should be made a part of inservice training offered by Mental Health staff to medical and other IHS Branches.

e. The Retarded

The problems of children and adults who are mentally retarded are not anywhere in the IHS Mental Health Program subject to a systematic study or organized program planning. Where, as has been indicated above, there is personnel within IHS interested in children, or where community involvement with special education and Headstart programs has elicited a response from the IHS Mental Health staff, there will be found examples of programs involving the mentally retarded. Notable examples are the evaluation and establishment of special education programs on the Zuni Reservation in the Albuquerque Area, the special nursery school-preschool programs established among the Apache in the Phoenix Area, at Yakima in the Portland Area, and the intensive school consultation programs by the psychologists in the Alaska Area.

In general, most attention has been paid, where this problem has been noted, to development of community based resources. However, at least one Mental Health Worker in the Navajo Area, who herself has a child in an institutional setting, has developed a sensitivity to the problems and emotional stress generated when such facilities are the only resource suitable or available.

To some extent the lack of development of these foci may be due to the small number of psychologists trained to evaluate children available to IHS, and especially to those available with cross cultural experience and ability to sift out retardation from culturally different patterns. It may be far more humane to err on the side of under detecting retardation as at present, than over detecting it because of cultural communication gaps and the labelling of differences as deficits.

However, for these reasons, or because of the initial stress on severe emotional illness, IHS Mental Health Programs have barely scratched the surface in serving this special population.

RECOMMENDATION:

27. The selective recruitment of more psychologists able to not only evaluate mental retardation, but also to aid schools and families in adapting local resources for the appropriate care and development of these children and adults.

f. Children with Hearing Loss and Deafness

This problem is one which has even less attention than retardation. It would appear that although Otitis Media was the subject of the second half of the AAIA conference on Indian Health in 1964, and was listed as a major problem by those assembled in 1972 by NIMH Minority Center to discuss needs of Indians in Mental Health, that surprising little has been done to develop care for the victims of the aftermath of this disease. The infections are now more readily brought under control, and much educational work in teaching the Indian families and communities to secure prompt early medical attention to earaches and infections is having an impact.

However, the final step, surgical restoration of partial hearing loss, is listed as an elective treatment, and the backlog of persons on waiting lists for elective procedures staggers the imagination. Thanks to the keen interest of Barry Mendehlsohn, M.D., MHCD fellow and child psychiatrist working with the Mental Health staff of IHS in Alaska, a good deal more attention is being paid in that Area to developing resources for children with hearing handicaps. Anecdotal evidence from that Area is replete with mention of children who were evaluated and treated at about age 5, and found to have a surgically reparable hearing loss. The family was told, and permission for the surgery obtained. However, the child entered school and often not until the age of 9 or 10 did the name come up on the waiting list. The child has had the problem of learning English as a second language, of acquiring fundamental elementary school educational skills, and of developing the habits of social interaction for several years with an invisible and unrecognized handicap. Schools and teachers in Alaska are usually unable to provide special services for this group of children, which may run as high as 40% of the classrooms in some places.

This handicap in the crucial early years, to say nothing of the traumatic experience of being suddenly summoned for a flight to a hospital for surgery several years after the condition has been diagnosed, are problems which require more than Mental Health Program input for solution. However, much that is now becoming familiar in Alaska because of the interest of a particularly dedicated staff person is probably also applicable to other Areas. As total mobilization of funding sources, community programs, and IHS medical and surgical personnel, Maternal and Child Health Specialists, occurs to meet the particular needs of this condition, the Mental Health Programs must be sensitive to their own potential contributions. The development of programs of evaluation, the need to work with families and teachers around the emotional reactions to hearing loss and deafness, and the liaison with all possible resources are the minimum parameters of an adequate program for this special population. Training of teachers and paraprofessionals in this sphere should also be considered.

RECOMMENDATIONS:

28. At least one person in each Area should undertake responsibility for developing a plan and program to meet the needs of those with hearing loss and deafness.

29. The possibility of utilizing Speech and Hearing Specialists as well as psychologists in Mental Health teams should be considered, and some way of securing these services, either through contract care or by direct employment, should be planned.

30. Since coordination of efforts is needed, inservice training of IHS staff in this field should be considered.

31. Since hearing loss and deafness are not limited to children, serious consideration should be given to evolving ways to meet the needs of adults who have these handicaps, and particularly of mediating the traumatic and emotional effects of this sensory deprivation.

g. Visual Handicaps and Blindness: Other physical handicaps

While the percentage of the population affected by visual handicaps may be small, two populations are particularly prone to these problems: the adult diabetic, and the young child subject to genetic defect, infection and trauma. The elderly person with cataracts and prebyopia should not be overlooked as well. A fairly comprehensive medical and health education program does seem to exist in most Areas, although often it is relegated to a low priority because of other traumatic and dramatic needs.

Similarly, medical attention is given to most crippling accidents and physically handicapping conditions. What seems to be lacking is the consistent attention paid to the psychological aspects of the disabilities and the need for communicating these to the teachers, other agencies, and families of the persons affected in such a way that effective planning and program development can be maintained and that the individual concerned can attain maximum self sufficiency and self respect.

RECOMMENDATIONS:

32. That in the planning of expansion and further development of IHS Mental Health Programs the specific needs of the visually handicapped children and older persons be considered as integral parts of the program.

33. That some staff in each Area be trained in the understanding of the psychological impacts of disabilities upon both individuals and their families, and be able to serve as a resource in training other staff as well as coordinating resources and making special evaluations in these areas.

7. Alcholism and Alcohol Abuse

Alcoholism and alcohol abuse have been frequently described as the "No. 1 Mental Health problem of the American Indian" by both Indian and non-Indian groups charged with planning for better programs and better living conditions for Indians both on and off the reservations. Perhaps it was a shake of particularly good fortune that IHS Mental Health Programs was not given primary responsibility during the past 10 years for developing alcoholism programs. Otherwise, this might have drained the resources of IHS so that the broad spectrum of services now available would not have been developed. Although the overall responsibility for alcohol treatment has rested largely with the local tribes under the auspices of OEO and NIAAA funding, IHS Mental Health staff have been involved in other appropriate roles.

a. Variety of Services Offered by IHS

Most Areas have developed a variety of services in this field as part of a reservation-wide network of services. The Billings Area has, for instance, in the past two years made a concentrated effort to make certain that such programs were mounted and maintained through every Service Unit in its territory. The model of providing consultation both to the Alcoholism counseling program of the tribes and to the local CMHC, as well as overseeing the development of a detoxification resource, as were done on the Flathead Reservation, is being spread over the entire Area, with appropriate local variations.

In other Areas some Service Unit programs have had more emphasis on alcoholism than others. The Turtle Mountain unit in Aberdeen has become almost nothing but an alcoholism program, and therefore the problem-oriented records show a high proportion of alcoholism cases being seen in the whole Area. More typical are probably the various supportive efforts in this and other Areas together with occasional special programs.

b. Indian Cultural Elements in Alcohol Treatment

Among the specialized programs are several that are built upon Indian cultural components. These may be blended with Alcoholics Anonymous and other models developed for mainstream cultures. One example is the Native American Church involvement in the program at Bessie, Oklahoma, which utilizes IHS consultation services. A culturally oriented program has been self-administered by an Indian population at the Chemawa Indian Boarding School. The Reno, Nevada Field Health Station (Phoenix Area) has developed a variation of Alcoholics Anonymous for Nevada tribes. The Navajo Area has found that utilization of a "buddy" to supervise the taking of medications enables a successful antabuse program to be operated. This is particularly true since among this population the effects of antabuse are well known, and being on such a program is a socially acceptable excuse for not drinking without being excluded from the peer group.

c. Moves Away from Complete Abstinence

Until the late 60's the field of alcoholism treatment has been dominated by theories based on complete abstinence. However, there is beginning to be some evidence that socially conditioned drinking patterns can be learned and modified. Levy and Kunitz in Indian Drinking Patterns spell out this idea from a research point of view.

A few IHS Mental Health programs have begun experimenting in this field. In Alaska at the Anchorage outpatient service, particularly, a few clients are being taught controlled social drinking patterns, and the same idea is being considered elsewhere in other Areas. This is a practical application of the observations of many researchers in this field, but is innovative and not yet fully evaluated.

d. Changing Funding Patterns

It begins to appear as though OEO and NIAAA funding may be phased out as demonstration funding, with the expectation that local communities support their own Alcoholism treatment and prevention programs. If so, it is not clear how Indian reservations without adequate economic bases can completely support their own programs. IHS Mental Health staff may have to become more directly involved as the staffing agency as well as the consultants to Indian alcoholism treatment programs. Already increasing amounts of special monies for alcoholism are showing up in the overall IHS budgets, and this phenomenon may increase (see p. 28). It is to be hoped that the balance of efforts will be maintained, since a full range of mental health services is needed by all the population, those persons suffering from addiction and abuse of alcohol as well as those who are not.

e. Need for IHS Inservice Training

A real problem in this field is the attitude of many non-Indian IHS staff of rejection and repugnance addressed to the alcohol using patient. In every Area there are tales that are far from apocryphal of physicians who do not use anaesthetic when repairing lacerations and treating injuries if the Indian patient has been drinking. There are other anecdotal bits of information to show a punitive or harsh attitude toward all Indians fostered by the stereotype that all Indians are alcoholics. Even IHS personnel in Mental Health have not escaped from this type of reaction, as witness the proposal to a Tribal Chairman that all alcoholics be sentenced to jail terms, with probation dependent upon not only abstinence but also on participation in a counseling program (Taos in the Albuquerque Area).

These attitudes, and the behavioral consequences of them should be carefully reviewed, and in-service programs developed to broaden the understanding of all IHS personnel.

f. Availability of Alcoholism Counseling for IHS and the non-Indian Community

Most IHS personnel do use alcohol, and a few abuse it. This makes it extremely difficult to offer counseling services to the Indian population, and not permit participation by IHS staff who may also need or desire such help. Yet the strict application of eligibility rules often denies help to federal non-Indian staff if only Indian programs are available. In Fairbanks, Alaska, the Tanana Council has become the alcoholism treatment source for the total community. Similarly the Warm Springs tribal program extends its services to non-Indians living within their reservation. In both these cases, as well as where other successful alcoholism treatment programs are mounted, it has become clear that a full range of Mental Health services is needed, of which alcoholism and prevention of alcohol abuse are only specialized aspects.

These problems of the boundaries of service, and of the evidence of great need without proven remedies, make the whole field of alcoholism treatment and prevention a complex and difficult one.

RECOMMENDATIONS:

34. That IHS Mental Health Program continue to support efforts to reduce alcoholism and the abuse of alcohol at all levels in the community. Consultation, detoxification, in-service training and even staffing such centers should be considered as appropriate tasks, provided that they are developed with community planning and controls, and provided that the aim is to establish a network of services utilizing all available resources and funds.

35. That in increasing its activity in the field of alcoholism the Mental Health Programs do not succumb to the overly simplistic thinking that if this one major problem can be solved that all Mental Health problems will be eradicated. A broad spectrum of services, based on the needs and desires of the Indian community, should be the basis for planning and budgeting.

36. That the IHS Mental Health staff be considered as a source for in-service training for all IHS staff in the field of alcoholism and that to adequately deliver such training specialization in this field be encouraged.

8. Drug Abuse and Inhalents

a. Heroin

Among the rural Indian populations with whom IHS is concerned, the abuse of "hard drugs" such as heroin has not been the major problem it has been in urban ghettos. However, occasionally it is introduced, usually by a returning Viet Nam veteran who became addicted overseas. Urban Indian populations are subject to the same stresses as other urban groups, and drugs are available as pseudo solutions without racial biases. However, up to this point in time (January 1975), no special Indian programs for addicts appear to have been needed.

b. Psycho-Active Drugs

Marijuana has always been available in the Southwest, but the publicity given it during the past decade has raised the same fears among Indian peoples as have led to panic and confusion among non-Indian school, church and family heads. IHS Mental Health staff have been available as consultants, resource persons, and speakers in this field, and with regard to the psychadelic drugs, the uppers (i.e., speed or dexidrines) and downers (sleeping pills, sedatives and tranquilizers).

Among the psychadelic drugs peyote has a ritual use in the Native American Church parallel to the sacramental use of wine in Catholic and Episcopal churches. The members of this pan-Indian sect are scrupulous about not abusing the sacred plant. However, they are suspect by Calvinist Protestant groups and other non members. As the youth counter-culture discovered peyote along with other herbs with psychadelic properties there has been occasional abuse of the peyote outside the Native American Church, spreading even to adults.

It has not, however, become a focal problem for any IHS Mental Health program.

c. Prescription Drugs

What has been a problem in the field of drug abuse is just that: the abuse of properly prescribed medications as uppers, downers or for their side effects of strange sensations such as dizziness and blurred vision. This problem is also prevalent in the non-Indian world, especially in suburbia. It is seldom discussed or dealt with effectively by either culture.

One outstanding exception is the program at Rapid City Indian Hospital (South Dakota, Aberdeen Area) where a cooperative in-service program with IHS staff has led to the marked reduction of prescriptions for tranquilizers and an increasingly appropriate early identification of anxiety and emotional distress. IHS Mental Health staff in Rapid City are seen as resource people by the IHS medical staff and are able to intervene early, as well as to shore their skills with other IHS personnel.

d. Inhalents

The sniffing of glue, gasoline, paint, and spray-cans with a variety of propellant gases is a fairly common addiction in the Indian population. Little comparative data is available, but this problem seems to be reported in non-Indian ghettos as typical of children and adolescents. However, it is well known in most Indian Boarding Schools, and in nearly every Area there are adults in their 20's who have serious brain damage and other complications arising from this addiction. Unfortunately, effective treatment is as elusive as effective treatment of chronic alcoholics, for perhaps similar reasons. Prevention through provisions of more stimulating activities for young people and very early intervention seem to be the only avenues of approach that are being widely utilized. The topic is often simply not discussed in formal reports from the Areas, although individual cases are sometimes described in Service Unit reports.

RECOMMENDATIONS:

37. That attention should be given to the possible use of the Rapid City Indian Medical Center program as a model for other IHS Service Units. This topic of the potential iatrogenic misuse of prescription drugs should be developed for all IHS staff as well as in-service training in recognizing and handling anxiety in medical and surgical patients.

38. That a real effort be made to survey the literature and practice in the treatment of those who use inhalents self-destructively. Effective intervention and prevention techniques need to be developed.

39. That the present case finding and educational programs regarding psychoactive drugs be continued with careful evaluation and modifications as locally appropriate.

40. That all IHS staff learn to distinguish between appropriate sacramental use of peyote and other herbs and their misuse and abuse.

41. That effective liaison with effective programs for treatment of addiction be maintained wherever local individuals and groups require these services.

9. Accidents, Violence and Suicide

Since the late 1960's was a period of national consciousness of suicide and the emergence of a discipline known as suicidology, it is not surprising that in every Area the Mental Health Programs of IHS developed suicide prevention programs and a concern for this self destructive behavior. This was perhaps most dramatically triggered by the occurrence of a suicide during a Congressional Committee visit to Fort Hall Reservation in the Portland Area. Certainly the kind of attention then focused led to the promulgation of data from several reservations indicating a high rate of suicide (up to 10 times the national rate).

However, later, more thorough, studies have revealed as great a variability in this behavior as along any other dimension that one seeks to measure for all Indians. There are also Indian tribes with one tenth the national suicide rate, and many where the rates of occurrence approximate the national average. Some efforts at selective attention to vulnerable tribes, and to the most vulnerable populations within those tribes seems in order, if this can be done without destructive labeling. (See James Shore, et. al. publications in the Portland Area chapter.)

At least one tribe which is proud of its very low reports of attempted suicides has an extremely high rate of fatal accidents. Some of these are due to the difficulty of securing prompt assistance and medical treatment in remote regions, but some are undoubtedly at least unconscious suicide gestures. This problem has not as yet been subjected to serious scrutiny, nor are data being collected to give a full picture of the situations that lead to accident proneness, and accident fatality.

There is some suggestion that a high suicide attempt rate may be a barometer of internal strife and frustrations reanhing the unbearable limits on a reservation (See Pine Ridge in Aberdeen Area). At times there seems to be a sudden reversal of the pent up hostility -- from the inward focus that results in a suicide attempt to an outward projection that results in violence and attacks on others -- both among the Indian population and directed against the non-Indian population.

Related to this is the situation in which the suicidal individual arranges a sequence of events in which some one else kills or attempts to kill the victim. The provocation of police or other persons to the point where they become violent and shoot to kill is not usual, but does occur, and most Area Mental Health staffs are familiar with it.

These behaviors are not peculiar to the Indian community, but in most other instances the individuals involved are not as well known to any health providing agency. In seeking solutions to these problems in its service populations IHS Mental Health could make contributions to the world at large that would have ready applications.

RECOMMENDATIONS:

42. Continuance of maintaining suicide attempt registers, and suicide prevention programs already established by IHS Mental Health staffs.

43. Careful scrutiny of accident and violent behavior to learn to detect self destructive patterns of violence embedded within what externally appears to be non-suicidal behavior patterns.

44. Maintenance of in-service IHS training programs to sensitize medical and nursing staff to signals of suicide vulnerability in individuals, especially in those regions where this is a high risk. At the same time that this program attempts to diminish the stereotyping of all Indians as high risks for suicide, efforts to avoid labeling populations with proneness to accidents and other self destructive behaviors should be made.

B. Issues Internal to IHS and Mental Health Program Administration

This next group of issues and recommendations is mainly concerned with matters relating to internal affairs of IHS and the administration of Mental Health Programs.

1. Evaluation

The need for adequate program evaluation is a thread which runs through this entire report.

First and foremost, evaluation should be geared to the needs of programs. Each of the components of the IHS Mental Health service has a more or less clearly articulated set of objectives. Ideally, evaluation should involve self-evaluation. How closely do actual accomplishments come to fulfilling program ideals?

Self-evaluation may suggest trends in service delivery which are not apparent on a day to day basis;;may stimulate rethinking and reassessment of priorities. Data of this type are rare indeed, but one might cite one example as an illustration. The Clinton Service Unit in Oklahoma reports the following figures for age breakdown of their patient population:

Age	1970-71	71-72	72-73	73-74
Less than 20	38%	35%	26%	26%
21-40	33%	34%	44%	51%
40+	29%	31%	30%	23%
TOTAL Patients	55	79	80	78

Some of the patient load during a given year are hold-overs from previous years. All this suggests that, as the program at Clinton has matured, there has been a shift from a high proportion of service time spent with a younger clientele towards an emphasis on a middle-aged population. It seems that middle-aged people are seen and retained in therapy, while there is no similar accumulation of long-term younger patients. This must raise questions: Is the explanation that there are adequate alternate resources for the young, do they not require long-term therapy, or is it that new intakes become closed off as service time is taken up more and more with long-term adult patients? Are the observable trends in keeping with long-term program objectives? The Clinton Service Unit experience is described in this detail, simply because it is one of the few examples of data available over time, at least prior to the development of the automated record-keeping system. It does serve to illustrate how such data can generate potentially useful questions.

Decentralization is one of the characteristics of the Mental Health Programs. It has many advantages which we address elsewhere in the report, but also some problems, one of which is the difficulty in insuring Area-wide, let alone service-wide standards, for programs. Again, the automated record-keeping system, which has as a component, the establishment of standards for clinical care, has promising implications. Peer review programs, such as the one being developed in the Billings Area, also have great potential in this regard.

Finally, the need for evaluation data in deciding how resources are to be allocated is obvious. It is inevitable that, given a condition in which resources are scarce, accountability will increasingly become an issue. The need exists for data which will meet the need for accountability within the Mental Health Program itself and to a variety of external agencies.

RECOMMENDATION:

45. Now that a certain state of maturity has been reached in its development, the Mental Health Programs should engage in continuous and on-going evaluation. The present report may be seen as a backdrop against which future evaluation projects can be projected. Internally-generated attempts at evaluation, such as the automated record-keeping system, should be supported.

2. Importance of Area-wide and National Staff Meetings

This issue is closely related to problems of centralized and decentralized administration of Mental Health Services within Areas and over the entire IHS. It is patently inefficient, and probably a sure way to 'burn out' good staff to organize an entire Area-wide program around a centralized staff of experts who make periodic visits to places at great distance. Some varieties of expertise, especially consultation, can be carried out in this fashion provided a regular schedule is maintained. However, the clientele of Mental Health Services cannot schedule their crises and their psychotic breaks for the third Tuesday of the month between 10 A.M. and 2 P.M. — and even if they could, there would hardly be sufficient time to deal with more than one, if that, in the itenerary of a regular circuit rider.

To be sure, in every Area except Aberdeen some form of this type of service delivery was utilized as an initial entry of Mental Health Programs into the reservations and the IHS system. However, once the usefulness of Mental Health Programs was established, demand for them became so great that some form of decentralization of the resources of professional personnel, as well as the training and establishment of paraprofessional local staffs was a second phase of growth and development.

The real need for close communication among Area Chiefs and the need for Area Chiefs and staffs to have contact with more than the bureaucratic aspects of the headquarters staff is keenly felt. From time to time in each Area an individual has expressed this need in succinct eloquence, and these remarks have been quoted in the Area chapters. The frustration of the administrative heads of programs has also been cited, as they find the need to be both clinician and training resource multiplied many times over.

There is an apparent feeling at the top and middle administrative levels of IHS that travel provisions for Area-wide and national Mental Health staff meetings are a luxury, a boondoggle, or a waste of scarce budget funds. There is little recognition outside Mental Health staff for the need for the informal as well as formal exchange of ideas, skills, information, and for the advantages of shared problem solving that can occur if there are regular meetings of Area Chiefs and of staffs within Areas. Only on the Navajo Reservation have regular staff training sessions been consistently held over the years, and these meetings seem to account for much of the high morale and the excellence of program development and service delivery in that Areas

Some sense of identity and relationship with IHS and with its overall goals for Mental Health Programs is visibly achieved at national training meetings, even though only two have been held. The importance of such meetings in counteracting the isolation and the fragmentation of program development should be much more carefully delineated. With the present large cadre of Indian paraprofessionals, particular success was achieved in delegating much of the planning of such meetings to the Indian staff members themselves in 1974. The need for communication and association of professionals with their peers was also not overlooked, and the resulting three days of shared experiences and stimulation gave a real sense of unity to a staff which is now too large to rely only on informal communications.

RECOMMENDATIONS:

46. That budgets and planning recognize the importance of at least quarterly Area-wide staff meetings, with agendas that include training as well as administrative matters, and at which all staff are expected to attend regardless of discipline, or Civil Service grade.

47. That no less often than every other year a national training meeting be held to include all levels and types of mental health staff.

48. That adequate support be given to these meetings to permit staff to travel and be lodged comfortably, with reasonable allowances for travel time.

49. That circulation of reports and exchange of ideas be encouraged at all levels and not be allowed to become a one way flow from bottom to top echelons.

3. Recruitment, Selection, and Retention of Professional Personnel

a. Psychiatric Manpower

The psychiatric manpower field requires special attention, since this is one indispensable element in a total mental health program and one which often characterizes the staff to outside agencies and other branches of IHS.

During the period of the establishment and expansion of IHS Mental Health Programs there was a resource for the recruitment of psychiatrists provided by the draft of physicians upon completion of their residency programs. A two year tour of duty with IHS satisfied the military obligation for most physicians, and also satisfied the personal needs of many who would otherwise have struggled with issues of conscientious objection to participation in the armed conflict in Viet Nam. Most, although not all, psychiatrists were drawn from this reservoir until the end of 1973.

There were advantages in securing the most recently trained and enthusiastic young psychiatrists by this method, but there were also disadvantages. For one thing there was seldom any opportunity to assess variations in maturity or the personal stability required if one is to successfully live in the rural and isolated locations of most IHS Service Units and Area offices.

As an example, the Billings Area had at least two unfortunate experiences in this connection, one with an Area Chief who was unable to resolve the dissonance between his liberal ideals and cross-cultural realities, and one with a psychiatrist who withdrew from IHS rather than live on a reservation.

Even mature personnel can suffer from culture shock and geographic isolation. The Alaska report of Verner Stillner, M.D., gives a frank description of his first year in Bethel. The scarcity of such material does not allow self selection or help orient new staff, yet one frequently encounters the attitude on the part of IHS personnel that this is a forbidden topic. Such a secretive stance is probably self defeating since it not only sets the stage for serious disillusionment, but the new staff member is also cut off from an open and frank discussion of his or her problems.

b. Other Disciplines

Secondly the young psychiatrist was often placed in charge, creating the problem of placing heavy administrative and leadership responsibility upon the shoulders of the least experienced of professional staff. Often the Social Workers, psychiatric nurses, and in later years the paraprofessionals had more experience in the cross cultural settings and with the bureaucracy of IHS than the most senior staff members in rank. To some extent beginning about 1972 this situation was taken into account, and Area Chiefs were appointed from other disciplines. This permitted the psychiatrist more opportunity to utilize his clinical training and consultation expertise as well as to develop the needed experience within the system if he chose to become an administrator. Other disciplines are needed for well rounded program development. In general, Social Workers have seemed rather plentiful in supply and to have presented few recruitment problems. Other professional disciplines are scantily represented. There are a few psychiatric nurses, psychologists, sociologists, and anthropologists, but not in the proportions one would expect. There has been some tendency to consider these professionals interchangeable, and in so far as they have clinical training, to consider their therapeutic skills equal to those of psychiatrists. To utilize all disciplines largely in clinical therapeutic work rather than for the particular skills of their discipline and training is apparently sound practice. However, it is difficult to justify a budget for a well rounded program if psychological tests, social group work and even routine psychiatric evaluations must frequently be purchased through contract care.

c. Role Responsibilities

Another problem which many professionals face when they come to the reservation is that of role definition: For example the role of physician as it is often learned includes an authoritative and perhaps authoritarian stance. This cannot work on reservations where much of the information required for successful functioning is possessed by others. The reaction to this recognition may assume the form of (1) discounting the value of this type of information (that's witchcraft and not science, I'm a physician not a politician, and so forth). A second type of reaction is to decide to throw out everything and become a complete neophyte. The correct stance seems to be a willingness to share information and decision-making without surrendering the authority which comes from possessing certain skills and having undergone certain kinds of training.

Perhaps the interaction between the Navajo Singer and Hand Trembler is prototype. The Singer does not make a diagnosis: that's clearly the responsibility of the Hand Trembler. On the other hand, the Singer has his own particular set of skills and experiences which equip him to do what he must and which confer his authority on him.

Mental Health professionals need to clarify their roles in the cross-cultural setting in ways which permit their specialized training to function while retaining the fewer territorial rivalries that are characteristic of IHS Mental Health Programs at present. The unique contribution of each discipline should have its place in the overall staffing pattern.

d. Recruitment Procedures

Recruitment procedures for all Mental Health staff are presently oriented to Area levels of the program and interested individuals are subject to preliminary screening at the Area level with validation at the headquarters level. There is seldom a veto of persons with acceptable credentials provided there are budgeted funds available. Although competitive applications occasionally occur, it seems more often than not that a position is filled by the only apparently qualified applicant, in an effort to increase the available manpower.

Recruitment literature in the past has emulated the Armed Forces in emphasizing the glamorous and the exotic elements of IHS service. Dependence on personal contact to fill in details and "wise up" applicants has left reality testing to chance. Sometimes it has placed IHS staff in conflicts of loyalty. Certainly applicants got mixed messages. Some of this is unavoidable. However, recruiting materials that are more realistically balanced would probably pay dividends in selective appeals and reduce ambiguities.

The process of recruitment and selection has only now begun to require formalization. The previous informal exchanges of information between Area and headquarters Mental Health administrators have been adequate in the initial stages. However, with the growth of the programs to the present size and maturity there needs to be some stability and emphasis on selectivity which matches persons with tasks and settings. It is presumed that as the job market outside IHS tightens, more and more candidates for IHS positions will be applying, and that more careful choices can be made.

Recruitment of Indians into professional positions is accelerating as a result of some national and local programs. This is probably not enough for what is obviously a long-term desirable goal. Further attention needs to be paid to questions like the factors conducive to stimulating interest in a particular field, appropriate academic requirements, and so forth. Most importantly, appropriate role models need to develop within IHS itself. Indian professionals within IHS are thus not only important because of the kind of experience they can bring to their jobs, but also because they provide role models for the future.

e. Retention of Professional Staff

A study of factors influencing retention and separation of professional personnel has not been made by IHS. The suggestions discussed here, together with pay incentives, special leave from Alaska to return "home", government sponsorship in securing advanced training outside IHS, and provision of government housing and military base priveleges, civil service retirement benefits, etc., have all been hypothesized as promoting retention. Isolation, poor facilities, cross cultural stress, travel demands, and family dissatisfaction are equally vigorously suggested as reasons for leaving IHS.

These factors need to be verified, as well as others identified, before realistic plans for retention of desired staff can be developed.

Meanwhile it can be noted that during this initial period of Mental Health Program development about half of the psychiatrists and most of those recruited from other disciplines have remained on beyond the two year initial tour of duty. This lends a feeling of some permanence and stability to Mental Health staffing patterns. However, there seem to be no clear cut career plans for any of these other disciplines, any more than there are clear recruitment policies which permit selection among competing candidates.

While at present the challenges of cross cultural work and the security of government employment seem operative in retaining nearly all non-psychiatric personnel, these factors cannot be left indefinitely to chance. Particularly, as more Indian and Alaska Native professionals become available, some serious consideration needs to be given to levels of experience, technical skills required for advancement and methods of differentially recognizing individual expertise. In short, a career lattice for professionals becomes essential if the continuity of program development and general benefits of staff retention are to be maintained.

In establishing this pattern some input from tribal and community persons should be provided as it is at the point of recruiting new staff. This is a complex problem, since most Indian and Native populations are aware that IHS has a two year commitment policy, and expects to transfer personnel at about two year intervals. The Mental Health Programs, with their interest in local adaptations of service delivery, have needs counter to this trend, but until personnel committed to longer stays have been garnered, it may be difficult to secure realistic feedback from local leaders.

As Mental Health staff do establish continuity and rapport with particular tribes they may well experience awareness of ways in which they are more welcome to participate in tribal activities than was at first apparent. One professional reported in an interview that for administrative reasons he had to make a decision to stay or leave after about 18 months on a reservation. Only in his final six months did he realize that the tribe involved would have liked him to stay — but by then it was too late to change his orders.

This gap in communication between cultures is also noted in several interviews where professional staff reported that tribal people become much more open after the crucial two year period has passed and it becomes clear that they will remain.

Senior staff in length of service should make some effort to reduce this gap and enable both Indian and non-Indian to express their honest feelings in time for decisions to stay or leave to be made appropriately.

RECOMMENDATIONS:

50. That the problem of adjustment to isolated living situations be more realistically faced by IHS as a whole. Dependence on rapid turnover to cancel out dissatisfaction is not a viable solution when the objective is to build community relationships with Indian and Alaska Native people. Instead, orientation programs, and supportive staff relationships, should be established for all personnel, and might be an especially appropriate task for Mental Health personnel to undertake.

51. Attention should be paid to appropriate orientation for new personnel. This orientation should include an appreciation of local culture and tradition, the history of IHS involvement and a knowledge of current programs, and frank discussions of such recruitment issues as role definition and problems of territoriality.

52. That sensitivity in selection be given priority, especially for Mental Health positions, since the misfit individual may do more harm to community relationships and programs than doing without staff for a little longer.

53. That recruitment materials be realistic as well as glamorous, emphasizing the challenges as well as the advantages of IHS service.

54. That a study of factors affecting retention in and separation from IHS be undertaken to verify the presently operating hypothesis about the relative importance of isolation, family pressures, pay incentives and intercultural social acceptance.

55. That Mental Health staff at the top administrative level work closely with physician recruitment and develop mechanisms for attracting top flight psychiatric personnel with long term commitments. Those instances where arrangements have been made for residents to work with Area and Service Unit programs as part of their

training should be noted.

56. The Residency training model might become quite appropriate for the recruitment of psychologists if internships could be provided. The potential critical staff for this purpose seem to be located in the Southwest where a large number of American Indian students is available, but opportunities for utilizing schools of medicine, social work, psychology and allied health fields in universities throughout the states served by IHS as well as some of the creative training programs in the East should be investigated.

57. That the present interest in trying to attract Indian professionals into IHS be encouraged.

4. Recruitment, Selection and Advancement of Paraprofessional Mental Health Personnel

a. Job Descriptions and Career Lattice

As has been indicated in other sections of this report there are no consistent IHS terminology, job descriptions, nor even a clear career ladder or lattice development for the paraprofessionals who make up 50% of the total IHS Mental Health component. To some extent there is awareness of this as a problem to be solved, and some efforts to develop career lattice job descriptions matched with training programs and requirements have been developed for discussion. This plan is included in the appendix to this report, but its status as an official document is far from clear. Most probably it should be classified as a working document, with some efforts to modify and clarify civil service procedures being based upon it.

The need for flexibility in matching job requirements to local needs and resources has often overshadowed the need of the paraprofessional staff member to have some clear routes for advancement and the potentiality of reaching an appropriate level of professional status in the course of long term service within IHS.

b. Training Curricula

To some extent this can be clarified by reviewing the job descriptions and abstracting the general principles and specialty skills into a coherent set of training programs. At the present time it does not appear practical from the experience of the Desert Willow Training Center staff to combine on-the-job training in specialties with a broad general Service-wide training program. Alaska and Billings as well as Navajo have developed training models of their own. Oklahoma City utilizes Fort Sam Houston's program for training enlisted level specialist technicians, while Phoenix and Albuquerque have utilized the Desert Willow Training Center. Many Areas have found it useful to adopt the Social Work Associate training model. Almost all Areas have attempted to arrange credit and supplementary courses through local academic institutions.

However, no one has analysed the overlapping elements in this wide variety of training programs. Also unidentified are the unique features developed in an Area, some of which could be transposed or duplicated elsewhere, or which are required because of characteristics of one region but not encountered in another.

Such an analysis is beyond the scope of the present report but needs to be done, preferably through an inter-Area and headquarters committee of IHS staff with outside consultation.

c. Administrative Problems

On the job the problems of paraprofessionals often reflect the divisions of opinion about how personnel should be utilized within IHS as a whole. Through Area and headquarters training, a Mental Health Worker may be skilled in crisis intervention, and have considerable expertise in delivering mental health services in homes and other places away from the Service Unit. Yet if a SUD feels that all IHS staff must report to a desk at 7:45 A.M. and stay on call in an office until the working day is over, the same paraprofessional may find himself or herself working double shifts without recognition. Trying to meet the needs of the tribal communities in the ways in which he was trained, while also avoiding a cut in pay for apparently not being on duty during "normal working hours" is destructive of morale and lowers effectiveness. This matter needs to be clarified in job definitions and descriptions. Solutions to this problem need to be devised in such a manner as not to entangle administrators in problems around fair employment practices laws, but solutions must also enable optimal deployment of the rich resources provided by having trained and competent mental health personnel drawn from the local Indian and Native populations.

When clearcut job definitions and curricular descriptions are developed, then not only can recruitment and selection procedures also be formalized, but administrative policies can be clarified. Retention of personnel will be greater. In general, natural attrition has weeded out some persons unsuited to this work, although it is probable that a fair percentage of those who have quit or been discharged could have been retained as valued employees if the terms of duty hours, and exact task performances could have been more clearly specified. In at least one instance the frustration over these issues provided the goading needed for an Indian paraprofessional to take a leave of absence and acquire a graduate degree. However, the disgruntled associations with IHS make it difficult for most such individuals to return to effective duty status.

d. Stress Inherent in the Paraprofessional Role

The Mental Health Workers are at present all local Indian or Native people. As residents in a local community they are in touch with the strengths as well as the weaknesses of the population to be served in ways that the non-Indian professional cannot be. These same circumstances, however, make the paraprofessional subject to stresses as great, although different, as those affecting transplanted outsiders. Often family and clan relationships affect the ability to maintain an objective stance. In visiting one Service Unit, the contractor happened to be present when a paraprofessional staff member was able to ventilate some of her feelings at attending the funeral of a cousin who had been murdered by another cousin. Both families were in need of Mental

Health services, and the strain might well have been unbearable if there had been no other IHS Mental Health staff close at hand.

While this may sound melodramatic, it is not an isolated event. In another Area a Mental Health Worker succumbed to the contagion of a suicide epidemic that was decimating her small community. Several men employed as Mental Health Workers are known to have resorted to alcohol abuse in the face of these demands on their competence and personal lives.

Solutions to this problem are worth developing. A sense of membership in an organization team seems of primary importance. This is facilitated if there is more than one Mental Health Worker in close proximity, especially if they can work together. Team work involving quickly available professional back up is also essential if these cooperative arrangements are to be most effective.

In the Navajo Area a sense of shared team support has been cultivated through Area-wide training meetings held on a regular and frequent schedule. Mental Health staff training needs are discussed in more detail earlier in this report. However, a secondary function of such sessions is the opportunity they provide for the Mental Health Worker to get away from his or her position of continuous responsibility and to permit some relaxation away from the local spotlight. To consider these sessions as "luxuries" or as mere excuses to "get a paid vacation" is pennywise and pound foolish.

Certainly the Mental Health Worker must be considered as a total human being, and the stress of the job relieved often enough that they can continue to function as links between cultures. This requires a concrete budgetary recognition of the unusual demands placed on this level of staff.

RECOMMENDATIONS:

58. The completion of work begun in defining job tasks, organizing these into a career lattice, and implementing the appropriate training programs or opportunities.

59. The analysis of existing training programs for paraprofessional Mental Health staff and development of training curricula geared to the body of skills defined. This should provide realistic opportunities for both personal growth and career advancement for Mental Health Workers, as well as provide for the increase in size of the cadre of paraprofessionals upon which community mental health programs are built.

60. Careful consideration of the problems of paraprofessional staff caught in the crossfire between professional Mental Health supervisors who do not have Service Unit responsibilities on a full-time basis, and Service Unit Directors who are attempting to organize uniform personnel policies.

61. If needed a ruling should be secured from the Fair Employment Practices Board that permits flexible hours for paraprofessionals, in a manner that equalizes their work load without incurring loss of coverage at clinical settings and without automatically requiring overtime for any activities outside of the normal business day. This is a delicate issue since exploitation of paraprofessionals by denying properly earned overtime should not be permitted.

62. Planning for the mental health of paraprofessionals at each Service Unit. This includes a staffing pattern which facilitates sharing the strains of local crises within closeknit communities and extended families.

63. Recognition of the value of periodic Area-wide and national meetings as sources of recreation and needed recharging of batteries as well as for their administrative and educational benefits.

5. Turnover of non Mental Health IHS Personnel

As Mental Health staff become stable, long term members of Areas and Service Units, one of the most discouraging aspects of the Mental Health Program development is the continual need to orient and train IHS personnel. Orientation toward cultural patterns, sources of stress, and personality interactions within the context of giving and receiving medical and health services is, of course, a legitimate mission for IHS Mental Health Programs.

However, there is within IHS a rhythm of two year tours of duty. Since Service Unit and Area Directors like to lose no more than half of their complement of medical officers and other staff at any one time, each year there is a high percentage of staff turnover. Just as good working relationships are established between the three elements of the local Indian community, the general IHS staff and the Mental Health staff, a phenomenon of fruitbasket upset occurrs. New personalities have to be absorbed and new staff have to be inducted all over again into the three way partnership. This is disruptive for program planning and continuity.

The continual introduction of new staff is particularly distressing since many of the newly recruited personnel have no concept of Mental Health Programs and services as well as little knowledge of local tribal culture. They often place their priorities in "scientific medicine" in their attempts to cope with the culture shock and the stress of new facilities, new colleagues, new climates and new terrain. Hence a continual selling job must be conducted "inhouse" regarding the role and function of Mental Health services. This consumes energies that many staff of Mental Health Programs, who are more stable in their placements, would like to direct to community problem solving and their own clinical efforts.

RECOMMENDATIONS;

64. That if such turnover phenomena are to be a continued part of IHS procedures, some effort to establish the bonafides of the orientation of Mental Health staff, and the importance of the consultation and program continuity which they have developed be incorporated into the folkways of IHS and its administrative policies.

65. Develop creative orientation tools including films, experiential situations, and written materials.

66. That perhaps, as has been tried in some limited degree, the efforts of Mental Health staff be more directed toward teaching the Indian community what to expect from and how to make the best use of physicians and other health service specialists, rather than on retraining IHS staff who are transient. This involves developing a kind of anthropology of the white majority culture and its health services structures, which may seem threatening to IHS staff at first. However, it might pay excellent dividends in greater ease of delivering services and reduce the number of traumatic incidents involving iatrogenic stress and mental or emotional crises.

67. That at some level of IHS Headquarters and of Area administration this policy of frequent rotation be examined to see if it is a carryover from the former quasi-military nature of USPHS. If so the value of modifying this set of policies, and establishing new traditions for IHS might be considered.

6. Separate Line Budgets for Mental Health Services

Several times tensions have been cited that arise because the Mental Health Programs of IHS have a separately appropriated budget, and hence are not closely controlled by policies set by Area Directors (IHAD). Mental Health staff sometimes seem to have funding for travel or other items that are viewed as luxuries by other IHS staff and Branches. This problem becomes particularly acute in times of inflation and shortage, when scarce resources must be stretched. Often the IHAD and his planning officers would like to re-plan and rebudget within a fiscal year in order to make certain that funds are most efficiently used. At such times the inability to transfer Mental Health funds can rankle.

The history of the separate budgeting for IHS Mental Health programs is somewhat obscure. At least two factors seem to have entered into the decision to administer the programs in this fashion. First, there was a surge of national interest in Mental Health in the 1960's that began under the leadership of the Kennedy administration and continued in the culminating development of the Comprehensive Mental Health Centers Act which was being funded at about the same time as IHS initiated its Mental Health programs. It seemed politically strategic to capitalize on this movement and its popular interest. Appropriations were thus sought for the specific purpose of developing mental health programs rather than being added as new items in the general IHS budget requests.

Secondly, there was a feeling of uneasiness shown in the 1964 AAIA conference on Indian Mental Health and echoed in many planning levels about the acceptability of a broadly conceived Mental Health Program to a large percentage of IHS. The possibility seemed strong that if a mental health program of a strong and innovative nature was to be developed it must be protected from being raided by unsympathetic administrators at a variety of levels of IHS. The separate appropriation for Mental Health provided protection from skeptical and disinterested administrators, and put the power to deploy funds and design programs directly into the hands of mental health professionals.

The resulting strength of these two interacting trends, and no doubt other factors, resulted in the present situation in which Mental Health Programs' funding is a separate appropriation from IHS general budget for all other programs. This has indeed accomplished the flexibility of program development and the establishment of both Area and national mental health objectives within the system.

However, even this separate appropriation has never been based upon an assessment of realistic need. The same total dollar amounts were at one time alloted to Pine Ridge Reservation, which is about the size of Rhode Island, and to Alaska, the largest state in the US. In general an estimate of how much could be usefully spent in the year's time by the staff at hand seems to have been often utilized as a budget figure. At no time was there a chance to estimate how much might be needed to introduce and sustain an ideal Area program or a national office.

Once programs were established, increases in budget required hearings and justification in the same manner as the overall IHS budget. At Congressioanl Budget Hearings questions of why one needs an increase or questions of details of service and staffing patterns are often asked at a level of detail that might not arise as regularly if this program were part of an overall budget planning process. This provides a public monitoring which has value, but it also places program planning in jeopardy each year.

Probably even more intricate are the local relationships with the Social Service Branch which is funded through the usual Area and overall IHS budget. As Mental Health Programs funded separately become more and more integrated with Social Services activities, and as staff come to be considered somewhat interchangeable, jealousies are inevitable. Apparently small inequities often irritate at the local, Area or Service Unit level beyond a reasonably tolerable plateau of bureaucratic frustration. Total program planning is difficult in such circumstances, and the disparities, real or apparent, can become issues in power struggles within the organization.

Few of these issues are pinpointed in this report since budget material at the Area and national level was not made available to project staff. Awareness of the tensions is, however, inevitable after any period of time spent in company with Area and Service Unit level staffs.

RECOMMENDATIONS:

68. The fundamental solution is to attain that state of effectiveness whereby planning for programs can be based upon realistic assessments of needs of the Indian population, presence of other resources capable of partially meeting those needs, and of the staff and specialties needed to be trained, recruited and retained to carry out the optimal program. In no branch of IHS has this kind of planning been fundamentally available. Some branches in some Areas more closely approach it than others, but all must somehow deal with the problems of stretching available funds in ways most optimal to meet the most obvious needs with whatever staff can be obtained.

69. Meanwhile, clarification of the reasons for the separate funding of Mental Health Programs within IHS, and a sharing of the planning functions more widely within Areas should aid considerably in increasing understanding and reducing needless rivalries. If each Area Mental Health Program were to grow to the size that its Chief could develop a staff for administrative assistance, then some of this problem could be overcome. Actually the assumption that good clinicians should

head programs and then stifling them with administrative detail is a poor use of resources. However, this pattern tends to be characteristic not only of IHS but of Mental Health programs in general. Creative solutions to these problems need to be sought. Precipitate and arbitrary solutions which reduce the flexibility and remove autonomy before there is service-wide acceptance of Mental Health Programs should be avoided.

7. The Problem of Institutional Racism within IHS and its Mental Health Programs

Institutional racism is defined generally as a series of policies, actions, and regulations that discriminate in a manner that is oppressive solely on the distinctions of race or color, and which are rationalized and justified on the basis of being for the good of the racial group they affect.

IHS is generally freer of these attitudes and policies than most governmental institutions established to serve American Indians, but it would be an expectation of staff that they be superhuman if one were to demand that no prejudice existed and that institutional racism was not at least incipiently present in IHS. Even men of good will can and do act in a manner which is unconsciously pejorative, prejudiced or oppressive, especially when, as in this federal institution, there are inherent assumptions of paternalism in the justification of the institution with which they are identified. Awareness of the operation of this tendency, more than any other single factor, is the best defense against it from within the institution of IHS.

Several examples of this phenomenon have been observed both within IHS as a whole, and in the Mental Health Programs specifically. One has to do with hiring and policies and procedures. Indian preference is certainly appropriate as a consideration in hiring new staff. Yet, policies for implementing it are disturbingly unclear. In general, the desired goal is that if two applicants who are equally qualified are available, the one who is of Indian descent and identification shall have preference. However, when qualifications vary between the applicants, this has sometimes operated to place the less qualified person in a preferred position. Sometimes when more than one applicant is in the pool from which selection is to be made, in some Areas there is operative a provision for participation by the local

Indian community — usually the Advisory Board — to have input into the hiring process. However, the mechanism for this is sufficiently unclear, and the qualifications for many Mental Health positions so poorly defined, that it is possible for the result to be a playing of special interests against one another in such a way that there can be no agreement and that positions remain unfilled. These maneuverings are familiar to anyone who has been involved with bureaucracies, and the addition of Indian preference to already complex procedures sometimes seems to elaborate rather than clarify hiring and promotion procedures.

Mobility geographically and up the career ladder is as important as initial hiring. It appears that there has been within IHS a policy that allowed Indian preference to operate to fill a position locally within an Area. However, as a hedge against the chance that this position might be filled by an unqualified person, the individual so hired was barred from full civil service status in relation to any other position within IHS. In other words, transfers, promotions involving an increase of responsibility for more than the original unit, etc. were not to be the normal expectations of individuals hired under Indian preference rules.

There are indications that this policy is changing, or that it may have been rescinded officially. However its operation was observed during the data gathering phase of this project. The justification of hiring someone who can work with that particular tribal group because they belong to it, followed by giving highly technical training, but then assuming that the individuals should not be asked to work with another group or in a broader setting is applied only to Indian personnel, never to non-Indian personnel. Non-Indian personnel are considered mobile geographically and vertically according to their ability and skills.

This becomes particularly significant as one looks at the long-range career prospects of the Mental Health paraprofessionals. In every instance these individuals are hired because of their ties with and expertise within a local community and tribal group. Their function as a link to the Indian community is extolled as the justification for the position and as one of its chief values when these positions are created and filled.

However, on-the-job training, formal educational opportunities, and experience often develop qualifications of the paraprofessional for technical competence beyond the limited interpretive role. They become therapists, psychometrists, social workers, and administrators. But they are immobilized by both the local preference policy described above and the job definitions and attitudes which tie them to specific localities and specific tribal associations. For some individuals the increases in pay and seniority in a home location may be sufficient substitutes for long range career plans, but for others the opportunity for geographic and career mobility is desired and should become available. Blocks to this mobility should not be rationalized as for the protection of either the community or the individual Indian person.

This type of problem becomes particularly apparent when administrative responsibility is involved. In one Area a paraprofessional was left in the ambiguous position of "Acting Director" for more than four years, with the justifications ranging from the fact that professionals (non-Indian) would not want to work under someone of lesser professional status, to statements that to expect the actual work to be done by the Indian person would be premature and too difficult. Neither of these explanations was justified over time, and that particular situation was rectified. However, within the Mental Health Service the situation has repeated itself more than once, and the option of administrative direction of local Mental Health programs, with the expertise of psychiatrists, psychologists, and Social Workers being appropriately used professionally under qualified Indian administrative direction has yet to become a viable model that can be replicated.

Placing American Indians in professional and administrative positions within IHS has proceeded with some vigor, within the Mental Health Program particularly. However, provision for supportive counsel which would enable these individuals to negotiate the intricacies of the bureaucracy has not always accompanied the appointment. It is as though the non-Indian who has arranged for an Indian successor has recognized and identified with those strengths of the persons involved which are most like themselves, but has failed to recognize the degree to which racial factors can operate to make difficult for one what are relatively simple negotiations for the other. Becoming more aware and more explicit about the incipient factors of institutional racism might alleviate some of the strains and stress involved in this desired transition period of placing the power to plan, develop and operate programs in the hands of qualified Indian personnel.

An inversion of this type of racism is found in those who are so afraid to intervene in a strange cultural setting, that they abandon their sense of expertise and become impotent. This seems to be entirely unnecessary, since the use of non-Indian modes of intervention, ranging from psychotherapy to consultation have been proven to be of value provided they are done with sensitivity and mutual respect for the parties involved. There is no reason to abandon a sense of appropriate evaluation of individal fitness for positions, or of performance within a position. Yet often the inverse relationship results not only in a sense of frustration and powerlessness on the part of the non-Indian, but in the blocking of honest feedback and performance evaluations of Indian personnel. This is less of an overt policy than an informal one, but it can be no less destructive of positive growth of programs and of Indian participation than overt discriminatory practice. Indeed, it may be more vicious in its effects, which ultimately lead to dissatisfaction of both races, and sometimes the destruction of what might otherwise be a good program.

In all fairness, it should be stated that prejudice exists on both sides of the racial boundary. The Indian population is often skeptical of overtures which seem to offer status and recognition only in return for becoming so like the non-Indian as to give up those parts of one's identity and culture which are specifically Indian. For these reasons, it is often difficult to develop free social exchanges, and free discussion of these problems which while shared, are seen differently by the two groups.

These differences in experience and perception also come into play in the physical setting of the delivery system itself. Upon arrival at most clinics or hospitals, the waiting rooms are arranged rigidly in rows, drinking fountains and restrooms are of minimal capacity, lighting is often poor, and receptionists remote from personal contact with those waiting for service. The provision of accommodations for relatives, especially small children and mothers, or the elderly, is often makeshift or non-supportive. Repeatedly efforts to rearrange seating, or to introduce other humanly adapted arrangements are resisted by mechanical and administrative means. Mental Health facilities are often in separate "trailers" requiring searching and difficulty in coordinating with medical services at another location. The conclusions drawn are that the facility is designed and operated for the convenience of non-Indian staff rather than for the consumers who are Indian. It is a subtle but persuasive indication of relative status and often of lack of respect.*

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*NOTE: There are exceptions, but the conditions described above tend to be the norm and the exceptions depend most often on the temporary presence of individuals with strong positive influence. With high turnover of personnel either through short tour of duty or frequent transfers at two year intervals, the exceptions of one year may revert to the norm of the next.

The policies of housing and off duty behavior of IHS staff also come into play. The closedness of the "compound" in which most IHS staff live, and the fears and the diffidence around participation in Indian activities are complex. A former Mental Health staff person who took a position with a tribal group remarked that he and his wife had not realized how closed the IHS was to outsiders until they found themselves in an outside position. Other Mental Health staff professionals who left the IHS comment that it was not until the die was cast that they began to realize that the Indian community did accept them, and that they did not need to leave. The pressures of IHS budget needs which force decisions six months to a year in advance, as well as its policy of constantly shifting personnel, set up real barriers to the culmination of relationship building which may take three or four years, rather than one or two. The justification used for these policies is that without them no one would be willing to work within the IHS at the professional level particularly, since the burden of isolation and cross cultural stress is too great, and that therefore they are needed in order to staff IHS and provide adequate health care. This involuted form of reasoning is one in which incipient racism can become entrenched.

IHS has made great strides in developing competent Indian staff, and is alert to recruit new Indian staff, particularly in the development of its Mental Health Programs. A sensitivity to the pitfalls of incipient institutional racism — from which no paternalistically founded bureaucracy can ever be quite free — and a willingness to open up these issues for clarification seems to be an important but often overlooked need of the system.

RECOMMENDATIONS:

70. That awareness of the possibility of institutional racism be developed, and plans made to develop sounder policies when present ones seem inadequate.

71. That some systematic effort be made to interview all persons presently and formerly a part of IHS to determine the multiple factors affecting the decisions to remain or sever the employment relationship. For Mental Health Programs this has particular relevance to the retention of psychiatrists and other professional personnel, and to the recruitment and selection of new staff.

72. That both geographic and career mobility potentials be made a part of all personnel policies involving Indian Preference, especially in relation to the paraprofessional.

73. That IHS Mental Health Programs continue to move in the direction of Indian leadership.

8. Tribal Programs

In spite of the problems already cited, there are many indicators that they are not insoluble. The many accomplishments of the Mental Health Programs in their first years are documented in the eight Area program sections of this report. In keeping with the publicly announced goal of IHS as a whole to enable Indian people themselves to participate in the planning, administration and operation of their own programs it is appropriate to cite the outstanding tribally operated programs in Mental Health.

White River Apache in Arizona has coordinated tribal council support with the Northern Arizona Comprehensive Guidance Center and other sources of support including IHS. While not completely tribally controlled, this program represents a significant step toward the creation of a service delivery network.

Bessie, Oklahoma, in the Clinton Service Unit is a halfway house and rehabilitation program administered by the Southern Cheyenne and Arapaho tribes. IHS achieved excellent consultation and supportive relationships with this program. Similar positive support from IHS for Indian Alcoholism programs can be found in the Billings Area (see Flathead Service Unit), in the Portland Area — in the Chemawa Boarding School project — and perhaps in relationships in Alaska with Native Health Boards.

However, the outstanding examples are the Mental Health components of the Papago Comprehensive Health Program (Tucson Sub-Area) and Warm Springs Tribal Health Program (Portland Area). Both programs are part of a comprehensive health and human services program operated by their respective tribes. Both comprehensive health programs are integrated with IHS in such a fashion that it would not be easy for a naive outside observer to determine that the Mental

Health component was not staffed entirely by IHS. Mutual respect is evident, and innovative, creative and adaptive programs have resulted.

Both programs are the result of many years of tribal planning and concern, which utilized but was not dominated by IHS consultation. Both have distinctive patterns of organization and administration. Both include many activities seen as desirable for community mental health and both function in a service network relationship to both IHS and other community agencies.

RECOMMENDATIONS:

74. Careful study of the Papago and Warm Springs Comprehensive Health Programs as models for integrating and adapting IHS and tribal operation of Mental Health Programs.

75. Continued support of these and other tribally planned programs in Mental Health in concrete terms of funding and assignment of staff without attempts to regain traditional non-Indian methods of control.

76. An increasing participation in networks of services utilizing local resources such as community Mental Health facilities, as well as tribal programs rather than building a disproportionate dependence on IHS alone.

V. MUTUAL RESPECT:
THE ESSENCE OF IHS MENTAL HEALTH PROGRAMS

This detailed list of accomplishments is impressive in itself and the list of recommendations is somewhat formidable. What is not conveyed by such a noting of details is something of the quality or atmosphere of the program which is palpable as an essence, but which is too elusive to specify objectively. This is the style of administrative organization which has allowed full scope to the creative problem solving capacities of those involved, both of the IHS staff and of the Indian communities with whom they have been involved. Basically, it might be defined as a mutual respect for the individual uniqueness, and a conscious seeking out of the strengths of all resources available. This attitude permits different patterns of working relationships and locally adapted characteristics to be equally respected so long as they are directed effectively toward the same goals of relieving distress.

Operating on these principles, IHS Mental Health Programs have developed a variety of models for service delivery:

1. The development of standard ortho-psychiatric teams, and conventional methods of consultation (See Portland, Alaska, Billings);

2. The use of psychologists, social workers and psychiatrists almost interchangeably as psycho-therapists (See Alaska, Navajo, and to some extent Oklahoma City and Phoenix);

3. The building of a basic field program on the generalized expertise of social workers and paraprofessionals with contracted psychiatric and other back-up service (Aberdeen);

4. The delegation of clinical responsibility at a professional level to Mental Health Workers (See especially Navajo), and finally;

5. An emerging administrative pattern of top level responsibility given to Indian Mental Health Workers who have available professional and paraprofessional staff as subordinates with expertise (See especially Pine Ridge and Rapid City in the Aberdeen Area).

This same flexibility in program development has permitted a wide variety of relationships to be established with other mental health resources. There are in at least three different modes for these relationships:

1. Contractual agreements with tribal programs (See Warm Springs in the Portland Area);

2. Contractual arrangements with Comprehensive Community Mental Health Centers (See, for example, Northern Arizona CMHC and White River Apache in Phoenix Area and Eastern Oregon CMHC in Portland Area);

3. Agreements for interchange of services between State Departments of Mental Health (See Alaska) or Public Health (See Oklahoma).

It has permitted the development of compatable working relationships with traditional healers in such a manner that, when qualified in their own cultures to do so, they can be paid as consultants on the same basis as medical specialists (See Navajo, Phoenix). It has permitted the experimentation with urban delivery of services (Rapid City; Los Angeles; Oklahoma City; Lawrence, Kansas; and Portland) as well as developing programs within the traditional catchment areas limited to BIA defined reservations.

Finally this mutual respect for individual skills and strengths has resulted in a high degree of staff commitment.

This has reflected itself even when professionals separate from IHS service, since many have remained available as part-time consultants after entering private practice or assuming other positions of responsibility at Universities or in other mental health systems. Outstanding among these have been former Area Chiefs of Mental Health Services James Shore, Portland Area; Carl Keener, Billings; Joseph Blocm, Alaska Area; Donald Burnap, Aberdeen. Others have been supportive of Indian program development and served on Task Forces where their knowledge and expertise can be widely applied in Indian cross-cultural settings. Outstanding examples are Carl Mindell, M.D. (American Academcy of Child Psychiatry) and James Barter, M.D. (American Psychiatric Association Task Force).

Among the non-psychiatrist personnel who have formally left IHS after a tour of duty with the Mental Health programs, a similar trend of continuing interest and support has been observed. Examples can be seen in the activities of Rosalee Howard, Ph.D., located in Eugene, Oregon, who continues to consult to BIA Schools; Norbert Mintz, Ph.D., who is publishing and teaching through McLean Hospital in Belmont, Massachussets; and a variety of paraprofessionals who have either left IHS to work in tribal programs, state programs, or to continue their education with a hope of returning to IHS as a professional staff member.

One must, of course, acknowledge that not all the experimental approaches have been successful, and that there has been attrition of personnel due not only to a self selection process, but on occasion to the lack of needed structure and guidance for developing personal skills needed by staff or lack of local support for individuals in remote locations. Nevertheless, the spirit of innovation and flexibility, and of respect for a wide variety of contributions to the reduction of human misery and the nurturing of human potential, is the outstanding characteristic of the IHS Mental Health Programs during their first decade.

This may be a developmental process, and these programs may now be entering a phase in which selection of the most effective models, the development of training programs based on tested principles, and the carefully discriminated recruitment of personnel will become characteristic. However, the essential spirit of mutual respect which interacts not only between the Indian cultures and the non-Indian, but also between professional disciplines and administrative models is the nurturing essence which, to quote for one last time from the Senate report, "have demonstrated what can be done, and how to plan for the necessary future expansion."

In essence the structure of Mental Health Program administration has been more like that of a network of service delivery units, each linked in a variety of ways to one another, than it has been a bureaucratic creation. This style has also fostered the extension of program development to include other agencies; tribal, private, state and federal. The essential interdependence of peoples has been recognized at not only the clinical level, but also in the integration of services and programs within the local context.

A final comprehensive recommendation is that even though the scope of the programs and the size of the Mental Health staff calls for some degree of formalization of previously loosely organized policies, that the essential flexibility, local autonomy, and creative innovation be preserved.

APPENDICES

A. Definition of Terms

B. Proposal for Mental Health Worker Position Series

C. Problem Oriented Record — Forms and Manual

D. INDEX and Bibliographical Listing

APPENDIX A

DEFINITION OF TERMS

There are a number of terms consistently part of Indian Health Service usage which may need explanation and translation for those not familiar with them. Among these are the following conventions:

Area, capitalized, always refers to the administrative unit having responsibility for service to a geographically defined territory. Area Office, not further qualified, refers to the headquarters of the Area and the policies of the Area Director (IHAD) and his assistants — Deputies, Program Chiefs, etc. Without capitals, area retains its common usage. Area Chief refers to the Chief of Mental Health Programs at the Area level, or occasionally, where so indicated, to Chief of some other parallel program such as Social Services, Maternal and Child Care, Field Health, etc. These programs are often called Branches within IHS.

Service Unit refers to the subdivisions within an Area which are functioning units. Service Units may be hospitals, or clinics with only outpatient facilities. They are usually named for the place, occasionally for the tribe or tribes being served. The SUD is the Service Unit Director, who is administratively in charge and who may or may not be a physician. A Service Unit may be further divided into Field Health Stations or Centers, staffed on a part- or full-time basis, and considered as satellites and auxiliaries of the Service Unit.

Contract Facilities are those facilities, particularly in these reports of mental health resources, which, while not part of the IHS, have a formal contract to provide certain services such as inpatient care, psychological testing, staff training, etc.

In a few instances a tribe may have organized its own mental health program, and contract with IHS for certain professional services, consultations, or use of facilities. These instances will be fairly clear in the text, and are not separated at this time from other programs at the Service Unit level.

Familiar standard abbreviations are used such as BIA for Bureau of Indian Affairs, HS for High School, OEO for Office of Economic Opportunity, CAP for Community Action Program. If there is doubt about clarity, these are i[illegible]fied and spelled out on first usage and abbreviated thereafter in each of the separately bound sections.

Terminology for paraprofessionals is not standard throughout IHS. Terms used include Mental Health Worker, Mental Health Technician, Psychology Technician, Social Work Associate, and Social Work Aide. Usage is usually consistent within an Area, and is reported as it is used in each Area. The measure of equating status among Areas would most probably be the Civil Service Grade and/or a job description. This matter will be dealth with in the Issues and Recommendations section of this report. The Aberdeen Area has attempted to develop a standardized classification and job ladder, which is presently being discussed, and which is based on Civil Service grades. It is included here as Appendix B.

PROPOSAL FOR MENTAL HEALTH WORKER POSITION SERIES

At the present time this proposal contains only the basic information developed by a committee in the Aberdeen Area Indian Health Service. It is assumed that it will be expanded and refined many times before it is submitted to the Civil Service Commission. In the development of this series we have assumed that the entry grade for the mental health worker would be GS-5 and that the journeyman grade would be a GS-9. It has been generally felt that this should be a double graded series and thus we have three levels, GS-5, GS-7 and GS-9. We suggest that grades GS-11 and higher will involve duties that would not necessarily be a part of this series, such as supervision and administrative functions.

This series is designed to be used for paraprofessionals in mental health, social service and related behavioral sciences. It is also specifically designed to be a guideline for those positions which involve working with people. As of the present it is not geared for research or teaching roles (existing position series, such as psychology technician adequately fill this need). Also a specific effort has been made to avoid slanting the roles toward a particular discipline, such as psychology or social work.

For each grade there is a general description of the degree of independent functioning at that level and there is also a description of the type of functions performed within the following categories:

1. Individual therapy
2. Group and family therapy
3. Advisor on cross-cultural factors
4. Utilization of existing resources
5. Working in community groups
6. Working with community leaders
7. Consultation

GRADE GS-5:

When the mental health worker first enters at this grade he will assume minimal responsibility and the supervisor will assign tasks, provide direction and review all work. As the mental health worker acquires experience and receives inservice training he will assume more independent functioning in that a supervisor assigns most tasks, provides general direction and makes regular frequent reviews of performance.

1. Individual therapy. The mental health worker will begin by developing a relationship and using natural unstructured responsiveness much as a friend or relative would do. With experience and training the worker will assist the patient in objectively reviewing alternative ways to approach problems to enable the patient to make better decisions.

2. Group and family therapy. At first the mental health worker will lead a discussion group to keep the group on the designated topic or common problem. Later on he will conduct groups focused on external problems in which the leader facilitates arriving at a solution.

3. Advisor on cross-cultural factors. At first the mental health worker will provide cultural information to people of similar background and with training and experience will interpret cultural information to people of different backgrounds.

4. Utilization of existing resources. At this level the worker will utilize familiar and readily available resources in providing patient care.

5. Working in community groups. With minimal training and experience the worker may be expected to represent his agency at community group meetings. With further experience he will be expected to bring specific information to community group meetings.

6. Working with community leaders. The worker will provide information and work cooperatively with community leaders.

7. Consultation. The worker is not expected to provide formal consultation at this grade.

GRADE GS-7:

At this level the mental health worker will assume a much greater degree of independent functioning. The supervisor assigns areas of responsibility, provides overall direction and periodically reviews performance.

1. Individual therapy. The mental health worker will perform supportive therapy working in a relationship to bring out the patient's psychological strengths so he can cope with immediate problems. At this level the worker must assume full responsibility for knowing when to refer cases. With experience and training at this level the worker will also assist a patient in using a crisis situation to become psychologically stronger.

2. Group and family therapy. The worker may perform family therapy focused on a particular problem situation.

3. Advisor on cross-cultural factors. At this level the worker will interpret cultural factors which have an impact on program planning and operation.

4. Utilization of existing resources. At this level the worker will also be able to search out resources that are not readily available to fit a patient's needs and with experience will improve and coordinate resources that can be utilized in patient care.

5. Working in community groups. At this level the worker will also be expected to give creative input to a community group to solve a specific task.

At the GS-7 level there are no additional functions in categories 6 and 7.

GRADE GS-9:

At this level the mental health worker assumes considerable independence in that the supervisor assigns general areas of responsibility, provides direction at the request of the worker and makes occasional reviews of performance.

1. Individual therapy. The type of therapy performed will not be substantially different from the GS-7 level except that the worker would be expected to handle more difficult cases.

2. Group and family therapy. At this level the worker may also be expected to conduct developmental and awareness groups (sensitivity, t-group encounter, etc.) composed of presumably "normal" people who are not designated as patients.

3. Advisor on cross-cultural factors. There are no additional roles in this category.

4. Utilization of existing resources. The mental health worker will also be expected to utilize and coordinate resources in the planning and development of programs.

5. Working in community groups. At this level the worker may also be expected to lead a community group and affect the process of that group so that they deal with problems more effectively.

6. Working with community leaders. This may also involve facilitating the leader's solving a specific problem.

7. Consultation - Inducing a change in the functioning of the consultee in his own area of expertise. At first, the mental health worker may provide consultation with one person in the context of a particular case or problem. With experience he may provide consultation involving a group of people but remaining within the context of a particular case or problem.

GRADES GS-11 AND ABOVE:

As mentioned previously it is assumed that advancement to these grades will be primarily related to the amount of supervisory and administrative functions performed. At this level the worker is fully responsible for functioning within areas of assignment and supervision is largely administrative. The worker seeks technical guidance on his own initiative.

At grades GS-11 and above the following functions may also be performed depending on the requirements of the specific job situation.

1. Individual therapy. This may include therapy to facilitate a major change in problem behavior or thinking. With considerable training and experience the worker may conduct therapy to facilitate a major character or personality change.

2. Group and family therapy. With appropriate experience and training the worker may conduct family therapy to affect a change in the family structure and functioning and may also conduct group therapy to affect major changes in problem behavior and thinking of the members through group process.

7. Consultation. The worker may provide consultation with one person in the context of a program or organization and also may provide consultation with more than one person in the context of a program or organization.

QUALIFICATIONS FOR THE MENTAL HEALTH WORKER POSITION SERIES:

The following material was developed at one committee meeting and considerable revision and additional work will be required.

FOR THE GS-5 GRADE:

A. The person must have the following:

1. Interest in other people
2. Personal warmth
3. Respect for others
4. Believing that people have the capacity to change
5. Understanding the necessity of confidentiality
6. Capacity to learn
7. Capacity to reason with continuums - avoiding polarized concepts
8. Ability to avoid applying one's personal standards to other people
9. Ability to be persistent when appropriate
10. Knowing that trust is essential in a relationship
11. Knowing that no two people are alike
12. Knowledge that a relationship requires acceptance

B. The person must have a "minimal" degree of the following items. It is assumed these will be further developed on the job:

13. Self-confidence
14. Reading and writing skills
15. Listening ability
16. Analytic thinking; ability to use a logical thought process
17. Ability to suspend decision-making when appropriate
18. The ability to remember the content and process of an interview
19. Ability to make a decision when necessary
20. Ability to set limits on personal emotional involvement
21. An awareness of one's own limitations
22. Self-awareness; understanding one's own personality
23. Ability to assess one's own relative position in a group setting
24. Ability to develop interpersonal relationships in a variety of styles

25. Capacity to understand the basic concepts of general systems theory
26. Knowing that development of a relationship follows a time sequence
27. Ability to differentiate and diagnose problem situations
28. Understanding how to treat various types of problems
29. Knowledge of the specific relationships of individuals and groups in a community

FOR THE GS-7 GRADE:

A. The person will need the above items for the GS-5 grade under "A" plus the following:

30. Knowing there are times when no treatment is best
31. Understanding of the concept that a relationship is the vehicle of psychological change
32. Understanding the concept that the client has the major responsibility.

B. The person will need a "medium" or "moderate" degree of the items for the GS-5 grade under "B" above plus the following. All of these will be further developed on the job:

33. Understanding that the pattern of past experience affects the present situation
34. Knowledge of the phenomenon of transference
35. Knowing that there are stages in life experience
36. A general understanding of group process

FOR THE GS-9 GRADE:

A. The person will need all of the items for the GS-7 grade under "A".

B. The person will need a "relatively high" degree of proficiency in the items for the GS-7 grade under "B".

FOR THE GS-11 GRADE AND ABOVE:

When the job at this level involves supervisory or administrative or other functions the qualifications, of course, would fit those functions. When the duties involved more complex functions within the categories described in this series the qualifications probably will be a refinement of some of those listed for the GS-9 grade.

The Mental Health Worker Position Series Committee includes: Joyce Johnson, Cecelia Lee, Francis Montileaux, Ned Byrnes, Al Folz, Paul Kirkham, Jim Rixner, Bob Riesenberg, Betty Glasow and Don Burnap.

APPENDIX C

Social Service and Mental Health Services Reporting System

Orientation Material

Social Services and Mental Health

Services Reporting System

PURPOSE OF THE PROJECT

The goal of the Indian Health Service is to raise the health status of the American Indian and Alaska Native to the highest possible level. To support achievement of this goal, it is essential that IHS and its component disciplines develop meaningful tools with which to plan programs, effectively allocate resources, monitor quality of performance, and measure and evaluate program accomplishments. Toward that end, the Social Service and Mental Health Programs plan to initiate an automated information system which will further enhance the effectiveness of IHS social and mental health services provided for American Indians and Alaska Natives. It is the objective of the Social Service and Mental Health Branches to:

1. deliver coordinated patient care through interdisciplinary Social Service and Mental Health programs.
2. identify high risk individuals for preventive programs through utilization of case registers.
3. report concise and meaningful information to the Service Unit, Area and Headquarters.
4. relate feasible and applicable national data to IHS social and mental health services as appropriate and available.
5. initiate some cost effectiveness mechanisms contributing to efficient program operation.
6. assure appropriate utilization of existing IHS Social Service and Mental Health staffs and community agency resources.
7. describe the need for additional services and staff in quantitative terms.

This is an initial protocol of the proposed automated information system. The input format is a machine readable form which contains a minimum of information required. As experience is gained in the development of this system and as various IHS professional groups initiate efforts toward data coordination, there will be changes in the program.

This initial Social Service and Mental Health Automated Reporting System has been coordinated with appropriate related disciplines and servicewide uniform reporting systems. It is consistent with Indian Health Service policy directions.

DATA COLLECTION METHOD

General:

Information concerning patient and community related activities is recorded on Mark Sense forms and submitted monthly to the IHS Data Center. An Optial Reader is used to transfer data from the forms to punch cards for computer processing of quarterly and annual statistical reports. This method of data collection and processing has proven successful in several other IHS systems such as the Dental and Public Health Nursing Systems.

Who Uses:

Designated personnel in the Social Service and Mental Health Branches of the Indian Health Service who provide services to patients, Indian groups, and/or communities complete the Social Service and Mental Health Services Report Form.

When Used:

Each member of the staff will prepare a Social Service and Mental Health Services Report Form for:

1. Each contact with, or on behalf of, a patient for whom services are rendered.
2. Meetings or activities such as work with communities or other agencies regarding patients and/or projects. (For Social Service personnel only, during pilot testing.)

Disposition:

1. Monthly, all service units will air mail the Computer Copies of their Social Service and Mental Health Services Report forms to the Area Social Service and Mental Health Branch Offices for review. Forms will be reviewed for appropriateness and returned to the service unit for necessary correction, as needed. A brief narrative report will be enclosed to alert the Area of projects, problems, progress and comments of the reporting worker.
    a. Each worker's monthly group of Social Service and Mental Health Services Report forms is to be accompanied by a Master Mark Form 15 which will indicate:

Area code
Service unit code
Program
Position code
Month and year

(These codes are obtained from the IHS Standard Code Book)

b. Each worker's forms will be submitted in a separate envelope. Each envelope will contain one Master Mark Form 15 placed on top of the Social Service and Mental Health Services Report Forms used that month.

(When packaging for mailing, make adequate provisions for protecting the completed forms from being torn or damaged in the mail.)

c. Each worker's envelope from the service unit will be packaged together in one larger envelope and air mailed by the Area office to the IHS Data Center by the _____ of the month, in order that the results may be tabulated for the month the activity occurred. The address is:

Data Processing Service Center
Indian Health Service
Room 4005
Federal Office Building and U.S. Courthouse
500 Gold Avenue S.W.
Albuquerque, New Mexico 87101

Processing at the data center will require approximately two weeks and reports will be collated and returned to the Area offices at the end of the quarter. The reports by service unit will be forwarded within five days to the service unit after receipt in the Area offices.

2. Errors

Any new system is likely to encounter errors in reporting on the forms. In order to assure accurate reporting, the forms will be checked for completeness by each service unit senior social worker or mental health consultant. In addition, the following edit checks will be made at the Data Center:

--Forms with two or more marks on the same line will be returned to the Area Office by the Data Center for correction and resubmission with the data collected for the following month.

--Forms with omissions will be included in the usual quarterly reports, but such omissions will be noted by appearing in the "Not Reported" column. For example: if the primary activity - consultation - is not marked by the worker, this omission will be reflected in the "Not Reported" column of the quarterly printout regarding activities. In addition, each service unit will receive a monthly error report indicating the nature and number of errors reported.

MONTHLY MASTER MARK FORM 15
For Use with Social Service and Mental Health Services Report

CARD CODE	1	■
	5	■
AREA		=0= =1= =2= =3= =4= =5= =6= =7= =8= =9=
		=0= =1= =2= =3= =4= =5= =6= =7= =8= =9=
SERVICE UNIT		=0= =1= =2= =3= =4= =5= =6= =7= =8= =9=
		=0= =1= =2= =3= =4= =5= =6= =7= =8= =9=
EMPLOYEE STATUS		=== IHS === Non-IHS
PROGRAM		== Social Services == Mental Health
POSITION CODE		=0= =1= =2= =3= =4= =5= =6= =7= =8= =9=
		=0= =1= =2= =3= =4= =5= =6= =7= =8= =9=
CALENDAR MONTH		=0= =1=
		=0= =1= =2= =3= =4= =5= =6= =7= =8= =9=
CALENDAR YEAR 197__		=3= =4= =5= =6= =7= =8= =9=

FORMS SUBMITTED BY: ______________________________

INSTRUCTIONS

1. Mark with number 2 pencil only.

2. Black in completely within dotted lines.
   (An example of a good mark is shown for CARD CODE above.

3. Write numbers in blocks /__/ as well as marking.
   (As shown for CARD CODE above)

4. Erase completely any marks to be changed. (A poor erasure will be picked up, causing form to be rejected)

5. Do not make any mark beyond the right hand vertical line.

6. Place this form on the top of each set of completed Social and Mental Health Services Reports for which the above information applies.

7. Each set of completed forms are to be forwarded in a separate envelope for processing.

8. A new Master Mark Form 15 must be filled out whenever any of the Master Mark information changes.

9. Instructions 1, 2, 3, 4 and 5 apply equally to the Daily Service Report forms.

SOCIAL SERVICE AND MENTAL HEALTH REPORT

RECORD COPY

1. PROJECT NUMBER

0	1	2	3	4	5	6	7	8	OTHER

2. PATIENT IDENTIFICATION

SS# — MARK ALL NINE LINES
HR# — MARK LINES FOUR THROUGH NINE

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9

3. COMMUNITY OF RESIDENCE OR PROJECT LOCATION

0	1	2	3	4	HUND.	5	6	7	8	9
0	1	2	3	4	TENS	5	6	7	8	9
0	1	2	3	4	UNITS	5	6	7	8	9

4. AGE

☐ UNDER 28 DAYS ☐ 28 – 364 DAYS

IF ONE YEAR OR OLDER, INDICATE AGE IN YEARS

0	1	2	3	4	TENS	5	6	7	8	9
0	1	2	3	4	UNITS	5	6	7	8	9

5. SEX

(MARK ONE)

☐ MALE ☐ FEMALE

6. CONTACT CATEGORY

(MARK ONE)

☐ INITIAL CONTACT ☐ RE-CONTACT ☐ NON-CONTACT (REGISTER UPDATE)

7. CONTACT CLASSIFICATION

(MARK ONE)

☐ IHS INPATIENT	☐ CONTRACT INPATIENT	☐ FIELD
☐ IHS OUTPATIENT	☐ CONTRACT OUTPATIENT	☐ OTHER

8. CASE REGISTER

0	1	2	3	4	5	6	7	8	9

☐ DELETE FROM REGISTER

COMMENTS

9. DIAGNOSIS—ICDA CODE (FOR DESIGNATED CONSULTANTS ONLY)

0	1	2	3	4	HUND.	5	6	7	8	9
0	1	2	3	4	TENS	5	6	7	8	9
0	1	2	3	4	UNITS	5	6	7	8	9
0	1	2	3	4	DECIMAL	5	6	7	8	9

10. PRIMARY PROBLEM CODE

0	1	2	3	4	TENS	5	6	7	8	9
0	1	2	3	4	UNITS	5	6	7	8	9

11. SECONDARY PROBLEM CODE

0	1	2	3	4	TENS	5	6	7	8	9
0	1	2	3	4	UNITS	5	6	7	8	9

12. PRIMARY PURPOSE OF CONTACT

(MARK ONE)

- ☐ INDIVIDUAL THERAPY
- ☐ FAMILY THERAPY
- ☐ GROUP THERAPY
- ☐ PSYCH TESTING
- ☐ COMMUNITY DEVELOPMENT
- ☐ CONSULTATION
- ☐ COOPERATIVE EFFORT
- ☐ EDUCATION
- ☐ GRANTSMANSHIP
- ☐ PREVENTION
- ☐ REFERRAL
- ☐ SURVEYS/RESEARCH
- ☐ OTHER

13. PRIMARY ASSISTING RESOURCE

(MARK ONE)

- ☐ CONTRACT RESOURCE
- ☐ HEALTH DEPARTMENT
- ☐ NATIVE PRACTITIONER
- ☐ PRIVATE INSURANCE
- ☐ SOCIAL SECURITY
- ☐ STATE/COUNTY
- ☐ STATE INSTITUTION
- ☐ TRIBAL ORGANIZATION
- ☐ VETERANS ADMINISTRATION
- ☐ VOCATIONAL REHABILITATION
- ☐ VOLUNTARY/PRIVATE
- ☐ WELFARE DEPARTMENT
- ☐ IHS
- ☐ BIA
- ☐ TITLE 18
- ☐ TITLE 19
- ☐ GRANTS
- ☐ HOUSING
- ☐ OEO
- ☐ EDUCATION
- ☐ EMPLOYMENT
- ☐ NONE
- ☐ OTHER

REVISIT DATE	REFERRAL TO
PURPOSE	PURPOSE
PATIENT NAME	DATE OF CONTACT / PROVIDER SIGNATURE

PROBLEM CODES

01 Abortion conflict
02 Adoption
03 Adult-child relationships
04 Alcohol misuse
05 Alcohol misuse in family
06 Anxiety
07 Arrested — currently jailed
08 Arrest record
09 Battered child
10 Bed wetting
11 Broken family (separation/divorce)
12 Child abandonment
13 Child neglect/abuse
14 Commitment to institution
15 Confused — disoriented
16 Cultural conflict
17 Day care
18 Death in the family
19 Delusions (false beliefs)
20 Depressed
21 Drug misuse
22 Drug misuse in family
23 Educational skills inadequate
24 Employment — part time/seasonal
25 Employment problem — on job
26 Family planning
27 Financial assistance
28 Financial needs
29 Foster home
30 Grief reaction
31 Hallucinations
32 Health, home maker needs
33 Housing
34 Hyperactivity (childhood)
35 Isolation — physical or social
36 Juvenile delinquency
37 Learning difficulty
38 Legal needs
39 Medical visits — multiple
40 Marital conflict
41 Mental illness in family
42 Mental retardation — suspected
43 Nursing home
44 Nutrition
45 Peer or sibling conflict
46 Physical complaint (no disease identified)
47 Physical disability — rehabilitation
48 Physical illness — acute
49 Physical illness — chronic
50 Pregnancy — unwanted
51 Probation and parole
52 School age parent
53 School behavior problem
54 School dropout
55 Sexual problem
56 Suicide attempt
57 Suicide attempt (family member)
58 Suicide thoughts
59 Suicide (family member)
60 Third party claims
61 Transportation
62 Truancy
63 Underemployment
64 Unemployment
65 Violent behavior
66 Vocational services
67 Other

General

68 Administrative
69 Inter-agency problems
70 Intra-agency problems
71 Jurisdictional complexities, legal
72 Lack of health service continuity
73 Lack of social and health resources
74 Lack of special education resources
75 Off-reservation problems
76 Orientation
77 Program planning
78 Public relations
79 Recreation
80 Resource development and utilization
81 Training
82 Urban community problems
83 Other

ICDA Codes for
Medical or Psychiatric Diagnoses
(To be used by Consultants only)

290 Senile and presenile dementia
291 Alcoholic psychosis
292 Psychosis associated with intracranial infection
293 Psychosis associated with other cerebral condition
294 Psychosis associated with other physical conditions
295 Schizophrenia
296 Affective psychoses
297 Paranoid states
298 Other psychoses
299 Unspecified psychosis
300 Neuroses
301 Personality disorders
302 Sexual deviation
303 Alcoholism
304 Drug dependence
305 Physical disorders of presumably psychogenic origin
306 Special symptoms not elsewhere classified
307 Transient situational disturbances
308 Behavior disorders of childhood
309 Mental disorders not specified as psychotic associated with physical conditions
310 Borderline mental retardation
311 Mild mental retardation
312 Moderate mental retardation
313 Severe mental retardation
314 Profound mental retardation

COMMENTS:

INSTRUCTIONS FOR COMPLETING SOCIAL SERVICE AND MENTAL HEALTH SERVICES REPORT FORM

A. General Information

The proposed Social Service and Mental Health Services Report Form is a two-part, carbonless form bound on the left side with printing on both sides to facilitate the following multiple uses:

Part I:

Computer Copy (Front) - Provide mark sense information for automatic data processing while maintaining confidentiality of patient information.

Computer Copy (Back) - Blank

Part II:

Record Copy (Front) - To provide a problem oriented record for Social Service and/or Mental Health files. This confidential document will include follow-up and referral information as well as case notes.

Record Copy (Back) - To provide for continuation of notes and for printing of the problem code list.

After completion of each patient or project contact, the Computer Copy of the form will be completed and held for monthly submission to the IHS Data Center. The Record Copy of the form constitutes a record of the contact and can be placed in the patient's file. Confidential information pertaining to patient contacts is to be confined to the Record Copy. The Computer Copy of the Social Service and Mental Health Services Report form should be removed before completing the bottom portion of the Record Copy.

B. Marking Instructions

1. Mark with number 2 pencil only.
2. Black in completely within dotted lines.
3. Erase completely and marks to be changed. (A poor erasure will be picked up, causing form to be rejected.)
4. Do not make any mark beyond the right hand vertical line.
5. Do not staple, bend, or fold forms.

C. Computer Copy of the Form

1. Required Data on All Forms (except Non-Contact Forms - see Box 6 under Specific Instructions)

   Box 3 - Community of Residence
   Box 6 - Contact Category
   Box 7 - Contact Classification
   Box 10 - Primary Problem Code
   Box 12 - Primary Purpose of Contact
   Box 13 - Primary Assisting Resources

2. Required Data on Patient Contact Forms - In addition to the above data, the following information is required for all patient contacts:

   Box 2 - Patient Identification
   Box 4 - Age
   Box 5 - Sex

3. Required Data on Project/Other Forms - In addition to the data required on all forms, Box 1 - Project Number is required for all project or other contacts.

4. Specific Instructions for Each Box

Box 1. Project Number - Mark Only One

Mark this box to indicate contacts for project and other activities. A "project" will be given a number from 0 through 8 by the worker. The title of the project, the problem to be solved, and the objectives to be reached will be written at the first contact on the Record Copy of the Social Service and Mental Health Services Form. The initiating worker will retain the Record Copy with detailed notes for his project files. The Area Social Service or Mental Health Branch may keep a record of the project initiated. A summary of the project and its results may be put in the monthly narrative report.

For activities such as meetings, case conferences, etc., mark Other in Box 1.

Box 2 - Patient Identification

In accord with IHS policy, Social Service and Mental Health Branches will use Social Security numbers whenever possible. In cases where no Social Security number is available or where the facility has not yet developed mechanisms for supplying Social Security numbers, the hospital Health Record number will be used. If the patient is off-reservation and/or has no Health Record number, the contact form will be held until the worker can obtain a Social Security number or have Health Records assign a number.

When "patient" is recorded by use of the Social Security Number, one mark must be made in each of the 9 lines provided in Box 2 of the form. When "patient" is recorded by use of the Health Record number, one mark must be made in each of the 6 lines below the dotted line in Box 2 of the form. Fill in patient number in both the vertical boxes and the mark sense positions.

Box 3 - Community of Residence or Project

Mark community code numbers according to the IHS Standard Code Book (Section V). All 3 lines of Community of Residence or Project must be marked on all forms. Unspecified or unknown community codes should be coded "999" as described in the IHS Standard Code Book (Section V-A, page 2). Patients from outside of the worker's Area should be coded as 998 unless that patient's community is part of the worker's routine service population, in which case the appropriate community code from the Standard Code Book should be used. In this instance, however, the code number and not the narrative will be printed on the computer reports.

Box 4 - Age

For patients only; mark as indicated on form. If age is unknown, make best possible estimate.

Box 5 - Sex - Mark Only One

For patients only; mark as indicated on form.

Box 6 - Contact Category - Mark Only One

1. First Contact - Mark if this is the first time the worker has seen the patient or the first contact initiating a project or other activity.

2. Recontact - Mark if a written record exists and a contact for the patient, project or other has been made previously.

3. Non-Contact - Mark to add or delete a person from a case register without making a patient contact. If Non-Contact is used, mark only patient ID, residence, age, sex, and case register.

Box 7 - Contact Classification - Mark Only One

Mark to indicate the classification of the current contact. Classification of contact is to be marked on all forms.

1. IHS Inpatient - Patient or project in IHS Hospital.

2. IHS Outpatient - Patient or project in IHS Hospital Outpatient Department, Health Center or Health Station.

3. Contract Facility - Patient or project in Contract Health Services facility or service.

4. Field - Patient or project in home, tribal office or other agency.

Box 8 - Case Register - Mark Only One - Optional

Case registers may be used as a working tool by service unit and/or Area staff. These case registers can provide a systematic method for:

1. Identifying and reporting population at risk relative to a problem or characteristic.

2. Providing preventive treatment.

3. Coordinating, utilizing and evaluating use of other local, state and federal resources.

Examples of registers are: alcohol misuse, suicide attempt, and services to the aged.

Each service unit and Area will decide together which registers are to be maintained. The register will then be identified by number according to the following guidelines:

Code Numbers 0 - 2 are for Service-wide registers
Code Numbers 3 - 6 are for Area-wide registers
Code Numbers 7 - 9 are reserved for service unit registers

This box is not required to be filled out on every form, but only in those cases where information is desired. These registers will be cummulative and only significant information which will be worked with for at least three years should be considered for a register. If there is no contact reported in three calendar years, the computer will delete the patient from the register to assure updated registers. If service is provided to the patient and the worker desires to take the patient off the register, mark the appropriate number for the register and mark the delete box. After a patient is placed on a register, it is still necessary to mark the appropriate case register number each time the patient is contacted about that particular problem. This facilitates inclusion of the most recent contact on the register printout as well as the capability for automatic deletion by the computer after three years of inactivity.

Box 9 - Diagnosis - ICDA Code (For Designated Consultants Only) - Optional

This box is to be used only by mental health or social service consultants when a definitive psychiatric diagnosis is made by, or known to, the consultant. Mark according to the four-digit diagnostic codes in the ICDA Code Book (8th Revision). The three-digit ICDA codes printed on the back of the form serve as a guide for finding the more definitive diagnoses in the book. However, if a three-digit code on the back of the form is sufficiently specific, it may be used in Box 9, leaving the bottom line (marked decimal) blank.

Box 10 - Primary Problem Code

This box must be marked on all forms. Use the two-digit code from the list printed on the back of the form (mark both lines for all codes). If problems were multiple, indicate the problem which was primarily discussed. If several problems were discussed of equal importance, the problem is the one the worker is attempting to resolve first.

Example: An Indian family consisting of parents and six children, dependent on BIA financial assistance, were referred to an IHS social worker following an automobile accident in which the father sustained head injuries. Problems in the family were: marital conflict; alcoholism of father and two older boys who are dropouts; unmarried, pregnant, 15 year old daughter; and repeated hospitalization of the two youngest children. Marital conflict was the primary problem, since family unity was the desire of all family members.

Box 11. Secondary Related Problem Code

This block is optional and will be completed only if the worker feels that the secondary problem has significant relationship to the primary problem. Example: The primary problem is "depression" but the related secondary problem may be "alcohol misuse." Use the two-digit code from the list printed on the back of the form.

Box 12. Primary Purpose of Contact - Mark only one

This box must be marked on all forms to indicate the worker's primary effort during any one contact.

1. Individual Therapy - encompasses psycho-therapy, casework, behavior modification, support, insight therapy, clarification, information giving, etc. with an individual patient.

2. Family Therapy - includes contact with more than one family member to improve social functioning. Family therapy includes conjoint family therapy.

3. Group Therapy - includes groups of selected individuals who may be helped to obtain a definite objective through planned group interaction. Example: individuals with a common problem are helped to understand the problem, alternative solutions and their ability to cope with or resolve it.

4. Psychological Testing - includes any psychological testing which may be done.

5. Community Development - is work planned toward improving the quality of life in the Indian community. Example: Coordination and mobilization of resources, participating with Indian community in obtaining funds for new services, etc.

6. Consultation - represents contacts with co-workers, consumer groups, agencies, community collateral contacts, family, school, or court to insure coordination, cooperation and effective use of services. Consultation may be for an individual or program.

7. Cooperative Effort - a joint approach to planning or problem solving with consumer groups, IHS staff or county, state or local agencies in attacking a health or social problem. Meetings would be listed here.

8. Education - participation in education for individuals or consumer groups, general community groups, CHR's, community health aids. Staff development activities will be reported under the narrative. Example: educational activities or training of social work students, associates, aids, or mental health workers.

9. Grantsmanship - providing groups with knowledge or grant resources, expertise in developing and writing programs that need funding through grant resources and work with tribal groups toward full utilization of these resources to meet community needs.

10. Prevention - preventive intervention is anticipatory patient community work to prevent disorganization or problems. For example: participation in Boy Scout or youth movement groups or support of off-reservation drug misuse programs to prevent problem spread to adjoining reservation.

11. Referral - Represents contacts for all services appropriately referred to a community agency or IHS services which is the primary assisting resource or because no IHS resources are available. The referral resource may be utilized conjointly with IHS services.

12. Surveys, Research - Represents the work involved in evaluating the needs of a community or patients, the effectiveness of services according to the consumer and outcome, formulating community diagnosis or special studies.

13. Other - Any activity which does not fit in any of the above categories.

Box 13. Primary Assisting Resources - Mark only one

Mark on all forms to indicate the primary resource contacted. Example: regarding a project, if the BIA is the key resource in the effective completion of a project, then mark BIA, even though a multiple agency meeting was attended and held in the tribal office.

1. Contact Resources - Refers to all facilities with contracts with Indian Health Service; includes hospitals, nursing homes, pharmacies, professionals, morticians, etc.

2. Health Department - Includes all state and county health services. For example: MCH, mental health, chronic disease, vital statistics, public health nursing, etc.

3. Indian and Alaska Native Treatment - Utilization of Shaman, medicine men, Indian healing ceremonies, etc.

4. Private Insurance - Utilization of any private insurance or resource for health care.

5. Social Security - Includes all Social Security programs except Title XVIII, Medicare, i.e., Social Security benefits, Social Security numbers.

6. State and County - Includes all state and county resources, but excludes Health Department and Welfare services, i.e., legal assistance, marriage, divorce, jail, sheriff, etc.

7. State Institution - Mental hospitals, special schools for the deaf, blind, or mentally retarded are included among these agencies.

8. Tribal Organization - Includes tribal governments, law and order, tribal social service, CHR's, housing, etc.

9. Veterans Administration - Includes all hospitalization, rehabilitation, outpatient or domiciliary care services, assistance with adjudication problems, etc.

10. Vocational Rehabilitation - All resources for vocational evaluation, training and physical restoration.

11. Voluntary/Private - Includes all private health and welfare agencies contacted, i.e., Red Cross, T.B. Association, Cancer, Kidney Foundation.

12. Welfare Department - Refers to all other than Title 19 services, i.e., child welfare, financial, homemaker, food stamp services, counselling, etc.

13. IHS - All IHS resources such as referral to IHS hospitals or facilities, environmental health or IHS programs or disciplines, including EEO staff.

14. BIA - Includes all BIA programs such as Social Service, Employment Assistance, Law and Order, etc.

15. Title 18 - Includes only medical care under Title 18 and efforts toward facilitating Indian people signing up for Medicare.

16. Title 19 - Refers to Medical Assistance Program used instead of IHS contact.

17. Grants - Includes all federal, state, and private grants available to Indians such as Hill-Burton, Emergency Employment, Ford Foundation, etc.

18. Housing - All agencies assisting in housing for individuals, families, communities and tribes.

19. OEO - Refers to all Office of Economic Opportunity programs, such as: alcohol, emergency food and assistance, work experience programs, etc.

20. Education - Includes public, BIA, boarding schools, vocational training and special education situation grade 1 through university.

21. Employment - Represents agencies helping individuals resolve problems related to employment, i.e., state employment agencies.

22. None - No assisting agency is used or needed in the contact.

23. Other - All others which are not included in the above list.

D. Instructions for Completing Record Copy of the Form

After completion and removal of the Computer Copy, the worker may complete the bottom section of the Record Copy for inclusion in the patient's file.

Comments including patient complaint, problem narrative, treatment regimen, etc. should be filled out utilizing the Problem Oriented Record (POR) concept as recommended by IHS. Comments may be continued in the space provided on the back of the Record Copy.

Revisit Date and Purpose is self-explanatory

Referral To and Purpose may be used for record purposes only or may be used to produce a referral document. If the information contained in the Comments section plus brief instructions in the Purpose of Referral Section is sufficient information for the person who is to receive the referral, then the Record Copy may be xeroxed and sent as the referral document without filling out the IHS Referral Form. Of course, in instances where a detailed case history or lengthy instructions are necessary, the standard IHS Referral Form should be used.

Patient Name
Date of Contact
Provider of Services - Signature
} Self-explanatory

POSITION CODE

01 - 10	Social Worker
11 - 30	Social Worker Associate Includes: Social Work Representative Social Work Assistant Social Work Aide
31 - 35	Sociologist
36 - 40	Psychiatrist
41 - 45	Psychologist
46 - 50	Clinical Anthropologist
51 - 60	Mental Health Nurse
61 - 80	Mental Health Worker
81 - 90	Alcohol Counselor
91 - 99	Other

Specific code numbers for each participating worker should be assigned by Area Mental Health and Social Services Branches within the above coding structure. Codes should be unique at the service unit level only, not Area-wide.

ROUTINE REPORTS

Title	Frequency	Distribution
# 1 - Patient and Project Contacts by Problem Category	Quarterly	SU, Area, Headquarters
# 2 - Patient and Project Contacts by Community and Population	Quarterly	SU, Area, Headquarters
# 3 - Patient and Project Contacts by Personnel Position Code	Quarterly	SU, Area, Headquarters
# 4 - Patient and Project Contacts by Primary Assisting Resource	Quarterly	SU, Area, Headquarters
# 5 - Patient and Project Contacts by Purpose of Contact and Contact Classification	Quarterly	SU, Area, Headquarters
# 6 - Five Leading Problems by Community	Quarterly	SU, Area, Headquarters
# 7 - Patients Seen by Age and Problem Category	Annually	SU, Area, Headquarters
# 8 - Patients Seen by Age and Residence	Annually	SU, Area, Headquarters
# 9 - Patient Utilization	Annually	Service Unit
# 10 - Case Register # 1	Annually	Service Unit

SPECIAL REPORTS

Number of Patients and Patient Contacts by ICDA Diagnoses	Upon Request	SU, Area, Headquarters

OUTPUT NOTE

Report # 1 - 5. The number of patients (different individuals) appearing in the column "Social and Mental Health Services Combined" will not necessarily be the sum of patients appearing in the "Social Services" column and in the "Mental Health" column. If the same person is seen by a Social Worker and a Mental Health Worker, he will be counted in the "Social Services" column and in the "Mental Health" column, but will be counted only once in the "Social and Mental Health Services Combined" column. Naturally, this is true at the Service Unit level only and when Social Services and Mental Health personnel are using the same patient numbering system.

Similarly, vertical addition of patients by Problem Category (Report # 1), Position Code (Report # 3), etc. may not correspond to the figure in the Total line at the bottom of the report. If a person has been seen for several problems or by more than one health worker, he will be counted as a patient for each problem or for each worker, but will be counted only once in the Total line at the bottom of the report.

REPORT # 1- PATIENT AND PROJECT CONTACTS BY PROBLEM CATEGORY

Reporting Period - ________________

AREA -
SERVICE UNIT -

	SOCIAL & MENTAL HEALTH SERVICES COMBINED				SOCIAL SERVICES				MENTAL HEALTH			
Problem Category	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities
Abortion Conflict												
Adoption												
Alcohol Misuse												
Anxiety												
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TOTAL												

QUARTERLY FOR SU, AREA, AND HEADQUARTERS

Report # 1 - The "Problem Category" list on the left side of this report will show only those problems dealt with during the period of the report - not the entire list of 83 problems.

AREA -
SERVICE UNIT -

REPORT #2 - PATIENT AND PROJECT CONTACTS BY COMMUNITY AND POPULATION

Reporting Period - ________________

	SOCIAL & MENTAL HEALTH SERVICES COMBINED				SOCIAL SERVICES				MENTAL HEALTH			
Community and Population	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities
Hardrocks (100)												
Hawley Lake (200)												
Hayden (420)												
Heber (500)												
Hickiwan (306)												
Higley (415)												
Hill Top (625)												
Holbrook (118)												
Hollywood (367)												
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TOTAL												

QUARTERLY FOR SU, AREA, AND HEADQUARTERS

Report # 2 - The "Community" list will appear on the Service Unit report only and will include only those communities dealt with during the period of the report. On the Area report, Service Units will appear in the left column. On the Headquarters report, Areas will appear in the left column.

REPORT # 3 - PATIENT AND PROJECT CONTACTS BY PERSONNEL POSITION CODE

AREA -
SERVICE UNIT -

Reporting Period - ______________________

	SOCIAL & MENTAL HEALTH SERVICES COMBINED				SOCIAL SERVICES				MENTAL HEALTH			
Position Code	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities
01												
02												
04												
Social Worker Total												
11												
12												
15												
Psych. Total												
21												
23												
26												
Mental Health Worker Total												
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TOTAL												

QUARTERLY FOR SU, AREA, AND HEADQUARTERS

Report # 3 - The left column on the Area report will consist of discipline totals (not individual workers) for each Service Unit. The Area total at the bottom will also be broken down by discipline. On the Headquarters report, the left column will contain discipline totals for each Area. The Headquarters total at the bottom will also be broken down by discipline.

REPORT # 4 - PATIENT AND PROJECT CONTACTS BY PRIMARY ASSISTING RESOURCE

AREA -
SERVICE UNIT -

Reporting Period - ____________________

Primary Assisting Resource	SOCIAL & MENTAL HEALTH SERVICES COMBINED				SOCIAL SERVICES				MENTAL HEALTH			
	No. of Patients	No of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Project Contacts	No. of Other Activities
Contract Resource												
Health Department												
Native Practitioner												
Private Insurance												
Social Security												
State-County												
State Institution												
Tribal Organ.												
Veterans Admin.												
Voc. Rehab.												
Voluntary-Private												
Welfare Dept.												
IHS												
BIA												
Title 18												
Title 19												
Grants												
Housing												
OEO												
Education												
Employment												
None												
Other												
TOTAL												

QUARTERLY FOR SU, AREA, AND HEADQUARTERS

REPORT # 5 - PATIENT AND PROJECT CONTACTS BY PURPOSE OF CONTACT AND CONTACT CLASSIFICATION
Reporting Period - ____________________

AREA -
SERVICE UNIT -

	SOCIAL & MENTAL HEALTH SERVICES COMBINED					SOCIAL SERVICES					MENTAL HEALTH				
Purpose of Contact	No. of Patients	No. of Patient Contacts	No. of Projects	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Projects	No. of Project Contacts	No. of Other Activities	No. of Patients	No. of Patient Contacts	No. of Projects	No. of Project Contacts	No. of Other Activities
Indiv. Therapy															
Family Therapy															
Group Therapy															
Psych. Testing															
Comm. Development															
Consultation															
Cooperative Effort															
Education															
Grantsmanship															
Prevention															
Referral															
Surveys/Research															
Other															
TOTAL															
Contact Classification															
Inpatient															
Outpatient															
Contract Facility															
Field															
Other															
TOTAL															

QUARTERLY FOR SU, AREA, AND HEADQUARTERS

REPORT # 6 - FIVE LEADING PROBLEMS BY COMMUNITY

Reporting Period - ______________

AREA -
SERVICE UNIT -

Community and Population		Problem # 1	No. of Patients	Problem # 2	No. of Patients	Problem # 3	No. of Patients	Problem # 4	No. of Patients	Problem # 5	No. of Patients
Hardrocks	(100)	Anxiety	26	Nutrition	18	Drug Mis.	14	Housing	12	Nursing Home	12
Hawley Lake	(200)	Housing	59	Alcohol Mis.	20	Nutrition	20	Anxiety	6	(3 Problems with:)	4
Hayden	(420)	Day care	40	[illegible]	37	Nutrition	33	Housing	27	Arrests	22
Heber	(500)	Alcohol Mis.	31	Depressed	11	Arrests	4	Training	3	(3 Problems with:)	2

QUARTERLY FOR SU, AREA, AND HEADQUARTERS

Report # 8 - The "Community" list will appear on the Service Unit report only and will include only those communities dealt with during the period of the report. On the Area report, Service Units will appear in the left column. On the Headquarters report, Areas will appear in the left column.

REPORT # 7 - PATIENTS SEEN BY AGE AND PROBLEM CATEGORY

Reporting Period - ____________________

AREA -
SERVICE UNIT -

Problem Category	Total Patients	Under 28 days	28 - 364 days	1 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 +	Unspecified
Abortion Conflict														
Adoption														
Alcohol Misuse														
Anxiety														
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ANNUALLY FOR SU, AREA, AND HEADQUARTERS

Report # 7 - The "Problem Category" list on the left side of this report will show only those problems dealt with during the period of the report - not the entire list of 83 problems.

REPORT # 8 - PATIENTS SEEN BY AGE AND RESIDENCE

Reporting Period - ________________

AREA -
SERVICE UNIT -

Community and Population	Total Patients	Under 28 days	28 - 364 days	1 - 4	5 - 9	10 - 14	15 - 19	20 - 24	25 - 34	35 - 44	45 - 54	55 - 64	65 +	Unspecified
Hardrocks (100)														
Hawley Lake (200)														
Hayden (420)														
Heber (500)														
Hickiwan (306)														
Higley (415)														
Hill Top (625)														
Holbrook (118)														
Hollywood (367)														
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ANNUALLY FOR SU, AREA, AND HEADQUARTERS

Report # 6 - The "Community" list will appear on the Service Unit report only and will include only those communities dealt with during the period of the report. On the Area report, Service Units will appear in the left column. On the Headquarters report, Areas will appear in the left column.

REPORT # 9 - PATIENT UTILIZATION

Reporting Period - ____________

AREA -
SERVICE UNIT -

Number of Patients Seen Only Once	94
Number of Patients Seen 2 - 5 Times	73
Number of Patients Seen 6 - 10 Times	29
Number of Patients Seen More than 10 Times	8

For Patients Seen Over 10 Times

Patient No.	No. of Contacts	Residence	Date of Last Contact	Comments/Name
000122	12	Sells	10-10-73	
000147	19	Sells	9-18-73	TO BE FILLED IN MANUALLY
001011	21	San Xavier	12-15-73	
002425	22	GuVo	11-04-73	

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(Appropriate List)

ANNUAL ONLY

SERVICE UNIT ONLY

REPORT # 10 - CASE REGISTER # 1

Reporting Period - ____________

AREA -
SERVICE UNIT -

Community	Patient no.	Age	Date of Last Contact	Comments/Name
Santa Rosa	00425	25	1-09-73	
	001191	11	2-09-73	
	001926	19	6-18-73	
	002171	64	8-21-73	TO BE FILLED IN MANUALLY
Covered Wells	001743	71	2-09-73	
	001819	12	8-20-73	
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(Appropriate List)				

ANNUAL ONLY
SERVICE UNIT ONLY

Patients are dropped from register if no contact is made within three years. Up to ten registers can be established by each Area.

Due to unforeseen circumstances the Index and Bibliographical listing were incomplete at the time of publication. A complete Index and listing will be bound in a seperate chapter and forwarded as soon as time allows.